Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Modification Submittal

Modification to
Integrated Community Mental Health Program

June 2003
For the period of August 1, 2003-March 4, 2004

Submitted by:
Washington State
Department of Social and Health Services
Mental Health Division
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US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

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PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Waiver Renewal Submittal

Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs), Prepaid Inpatient Health Plan (PIHPs), or Prepaid Ambulatory Health Plan (PAHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and CMS's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for CMS to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated waiver renewal submittal includes new requirements in the Medicaid Balanced Budget Act (BBA) regulation for managed care published June 14, 2002. States have until August 13, 2003 to comply with these requirements. States that want to submit a renewal request prior to August 13, 2003 that complies with pre-BBA requirements should use the September 23, 1999 version of the preprint. (2) States must still have MCO contracts and capitation rates prior approved by their CMS Regional Office (RO). PIHP/PAHP contracts and capitation rates must also be reviewed and approved by the CMS RO.

CMS staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their CMS Regional Office to identify required submission items from this format.

Instructions

This waiver renewal submittal builds upon the September 23, 1999 format for a waiver renewal request. It is essentially the same document but includes the new BBA requirements as well as some editorial changes.

Each section starts with one or more items under the heading "Previous Waiver Monitoring." The first question in "Previous Waiver Monitoring" asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State's monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate). Additional questions may be asked as appropriate.

Following "Previous Waiver Monitoring" is the subsection called "Upcoming Waiver Period." Its purpose is to give the State the opportunity to describe the waiver program for the next two years.

Please fill out the form in its entirety.

Waiver Submittal Instructions (See State Medicaid Manual 2106)

Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO, PCCM and PAHP programs for dental or transportation services:

CMS, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For PIHP/PAHP programs focusing on Behavioral Health or Elderly and Disabled populations:

CMS, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate CMS Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information that is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of CMS receipt of the State's complete response to the request for additional information, or the waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day after the day the waiver is received by the addressee (i.e., the Secretary, the CMS Central Office (CO), or Regional Office (RO) designee) and ends 90 calendar days later. By 90 days, CMS must either approve the request, disapprove the request, or request additional information.

General instructions

States should check all items that apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- A number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- All items are applicable to MCOs, PIHPs, and PAHPs unless otherwise noted.

- When sections require explanations, please insert the explanations into the document itself instead of attaching the explanation as an appendix, if possible.

- Because this is an application for a renewal of an existing waiver, CMS is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to ensure a complete submission package and to minimize the amount of additional information requested by CMS, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- Please update the table of contents prior to submitting the waiver to CMS to reflect the current page numbers and appendices.

- Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a (Upcoming Waiver Period) is the attachment for question a. under point I. Elements of State Quality Strategies (Upcoming Waiver Period) in Section C.)

Amendments or modifications during the renewal period

During the renewal period, a State may wish to modify their Section 1915(b) waiver program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

CMS considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

CMS reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approvals of modification requests are effective from the date of approval through the end of the renewal period.

CMS receives a variety of waiver modification requests, which range from being minor in nature to extensive.

Regardless of the extent of the needed modification, a State must submit an official request for modification to CMS as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

Section A. GENERAL INFORMATION

The **State** of Washington requests a waiver under the authority of Section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

Effective Dates: This waiver modification is requested for a period of 7 months; effective August 1, 2003 and ending March 4, 2004.

The waiver program is called Integrated Community Mental Health Program.

The State of Washington, Department of Social and Health Services, Mental Health Division (MHD) is moving all relevant pieces of its integrated community mental health program into this waiver modification. The original waiver was approved in 1993, amended in 1997 and has been renewed every two years. The document, including formal questions and answers, has become very cumbersome with the requirements spread throughout making it difficult for CMS, the State, the provider of service, allied systems and most importantly the consumer, to understand what is included, what has changed and what has been deleted over time. This clarifying modification request is intended to supercede existing documents and be the point for monitoring and contracting. If former requirements are not marked or moved forward, they are no longer included.

State Contact: The State contact person for this waiver is Paul Montgomery and can be reached by telephone at (360) 902-0864, or fax at (360) 902-0809, or e-mail at montgpr@dshs.wa.gov.

I. Statutory Authority

a. Section 1915(b)(1): The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

b. Other Statutory Authority: The State is also relying upon authority provided in the following section(s) of the Act:

1. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list in Section A.IV .d.1 and Appendix D.III additional services to be provided under the waiver, which are not covered under the State plan. The services must be for medical or health-

related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval.

3.__x_ **1915(b)(4)** - The State requires enrollees to obtain *mental health* services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

c. **Sections Waived.** Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1. _x_ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. ~~This waiver program is not available throughout the State.~~ *This waiver program is implemented statewide. It may be necessary however, if at any time the RSN can not, or chooses not, to demonstrate qualifications, for the State of Washington to implement a fee for service system on a time-limited basis to implement a procurement process for that geographic area. This would be done thoughtfully as covered in the contingency plan submitted to CMS to not disrupt care to consumers.*

2. _x_ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. _x_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO, PIHP or PAHP.

4._x_ **Section 1902(a)(4)** – To permit the State to mandate beneficiaries into a single PIHP or PAHP.

5._x_ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

Section 438.10 Information requirements- The MHD is seeking waiver to the following subsections (e) and (f) to allow the State to provide basic informing materials. As a cost-effective way to meet this mandate, the MHD is producing the basic informing material rather than the PIHP. The administrative cost of providing that information in this detail to all Medicaid enrolled will have a direct result of less funding for direct service delivery. The mental health program is mandatory for all Medicaid enrolled for FY02 (812,575) of which approximately 10% (82,130) utilize the public mental health system. In printing and postage alone, this is an estimated administrative cost saving of over $1,000,000 per year. Additionally, the MHD knows by experience that the mass mailing to Medicaid enrollees about their mental health angers the population. They call the division to complain and ask that they be removed from future mailings.

The MHD will assure information in the following ways. The MHD will make information available at the first point of approval of Medicaid eligibility, including the list of relevant contact information for both the state and the RSN. In the letter received by each Medicaid enrolled individual from DSHS there is a paragraph explaining their mental health benefit and how to access mental health services. That section reads:" Mental illness affects many of us at some time in our lives. As a part of your Medicaid coverage, you can get mental health services such as: case management; therapy; medication management; hospitalization or crisis services, should you need them. Look in the phone book for crisis service numbers. Other mental health services are available to you through a Regional Support Network. Ask your worker how to contact them."

The complete information package on their mental health benefit will be available at the Community Service Office (CSO), the Community Mental Health Agencies, and the RSN offices, or through the Involuntary Detention process if this is their first contact with the mental health system, on the Mental Health Division's website and/or by calling the MHD's 1-800 number. Additionally, there will be a postage paid postcard in their eligibility package allowing them to request the full benefit notice at any time from the MHD.

In addition, a notice will be sent annually to all Medicaid enrollees with a reminder notice that more information on their mental health benefit is available at the CSO, on the Mental Health Division's website and/or by calling the MHD's 1-800 number and requesting a copy. This notice will be sent during mental health month in May. The PIHPs are required to provide supplemental information on significant benefit change directly to those consumers accessing mental health services.

There is reference to these informing requirements throughout the regulations. To the extent necessary, waivers are requested to those sections requiring PIHP's/state obligations to inform all enrollees; to allow informing of all enrollees upon request and those who are accessing mental health services, consistent with the conditions described in this waiver of Section 438. 10.

Section 438.52 Non-competitive Procurement - The MHD continues to rely on its agreement with the Centers for Medicare and Medicaid that the Regional Support Networks (RSN) are the entities that have the first opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.

The first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks. The first opportunity provision was contingent upon the RSNs agreement to enter into a full-risk capitation contract at an actuarially sound rate determined by the MHD. RSNs were also required to demonstrate capacity to meet the program and fiscal requirements. The RSNs administer the Medicaid mental health care system directly, or subcontract with qualified community mental health agencies (CMHA). Such subcontracts do not relieve the RSNs of ultimate responsibility for compliance with the MHD's program and fiscal requirements. RSNs may impose additional requirements on subcontractors as may be needed to affect appropriate management oversight and flexibility in addressing local needs.

Pursuant to the State's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act

(RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as services for people with developmental disabilities. All RSNs shall meet the requirements of RCW 71.24 as a certified RSN or a licensed mental health agency and the requirements of RCW 48.44, as applicable.

Counties are also responsible for local criminal justice systems, including local jails and juvenile detention facilities. As a result of these diverse but interrelated responsibilities, RSNs maintain a unique position to facilitate coordination and integration of their existing program responsibilities with the managed mental health care system to provide seamless care for people covered by Medicaid. Moreover, based on their long history of experience in administering mental health programs, the RSNs are knowledgeable about the comprehensive needs of the high risk populations included in this managed mental health care system.

RSNs have a growing responsibility for the coordination of improved services with the correction system. The RSNs have developed triage, jail diversion, post-prison and community transition.

If an RSN chooses not to participate in this initiative, or is unable to meet required qualifications, the MHD will secure an alternate contractor. *This would be done thoughtfully as covered in the contingency plan submitted to CMS to not disrupt care to consumers.*.

The MHD ensures that whether an RSN-based PIHP or other entity holds the mental health managed care contract, that contractor is required to provide an integrated system of mental health service delivery and control per enrolled costs. This system ensures access to quality mental health services while managing the rate of expenditure growth of the overall system.

Section 438.52 Choice – All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP in their catchment area. The state is requesting authority to waive 438.52.

Section 438.56 Disenrollment - Per the training in Seattle, the program operated by the MHD is not required to offer disenrollment. Based on the ten years that we have operated the waiver, there has been a very small number of requests and only one approval. There is currently no alternative fee-for-service system available

Section 438.236 – Practice Guidelines - The state and its contractors will be reviewing and possibly adapting some of the guidelines by APA distributed in the last 2 years.

Section 438.354- EQRO Requirement - The MHD will utilize the three mandatory protocols however this is a new process for mental health. This request is to only be allowed to use the eastern branch of the Washington Institute for Mental Illness Training and Research (WIMRT) as a proxy external review organization for the first year of this requirement.

II. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any

program changes either planned or anticipated during the requested modification period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

The purpose of this waiver modification is to continue to: 1) promote age, culturally[1] and linguistically competent, coordination of comprehensive mental health services with regionally managed care through Prepaid Inpatient Health Plans (PIHP); 2) provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner providing continuity of care for persons served by the public mental health system; and 3) support recovery and reintegration to the community for persons with mental illness.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created county-based RSNs to design and administer mental health delivery systems to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering mental health services under a 1915 (b) waiver in 1993, for outpatient mental health services. The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This established the ability to control the rate of financial growth and improved mental health service outcomes. The mental health services covered under the waiver were the full range of community mental health rehabilitation services offered under the Medicaid State Plan through a fee-for-service reimbursement system. These mental health services stress ongoing community support to provide the enrollee with tailored services that are responsive to their individualized needs. It is the State's intention to manage the costs of the community program while continuing to target service to the most disabled enrollees with well-coordinated services. It is also the State's and the RSN's intention to utilize the managed care concept to provide persons with mental health services necessary to help them become reintegrated or recovered community members. The most flexible service delivery model available can help to accomplish these goals.

In 1997, an amendment to the existing waiver was approved which incorporated community psychiatric inpatient services for adults, older persons, and children into the capitated contracts with the RSNs. This

1 **Cultural competence is defined in the mental health system as:**
""Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs."

integration furthered the principles of mental health reform and improved the services provided to enrollees. An essential component of the waiver amendment was to provide the RSNs the first opportunity to demonstrate qualifications and enter into an integrated full-risk capitated mental health services contract with the MHD. The MHD took this approach due to the existing unique structure of mental health and human service delivery systems administered by counties and the RSNs under state law. Pursuant to the State's Community Mental Health Services Act (Revised code of Washington (RCW) 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as providing for people with developmental disabilities.

The statewide mission and values are the basis of all aspects of mental health service delivery, interpretation, and implementation of the waiver and the RSN contracts. They are:

Mission Statement

The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community.

We are committed to take actions consistent with these values:

1. We value the strengths and assets of consumers and their families, and seek to include their participation in decision-making and policy setting.
2. We respect and celebrate the cultural and other diverse qualities of each consumer.
3. We work in partnership with allied community providers to deliver quality-individualized supports and services.
4. We treat people with respect, equality, courtesy and fairness.

Stakeholder involvement and advisory committees

The public mental health system in Washington State was, and continues to be, developed with significant stakeholder and consumer involvement. This is not a new process for the MHD. It is one that has its roots from the 1970's. The MHD receives stakeholder input in a variety of ways.

Consumer and family voice and recovery is the foundation of the mental health service delivery system. The MHD believes that those persons being served should drive the system. The system and advocates are seeing the impact of consumer voice both in policy development and service delivery, and in the structure of the way in which services are delivered. There are many arenas where the MHD collects input from consumers and their families:

- The MHD Office of Consumer Affairs (OCA), in the MHD, meets quarterly with consumers, parents, and advocates. Frequent and consistent communication assures an accurate understanding of the points of view of consumers, parents, and other family members, which is then incorporated into the workings of the public mental health system. The OCA reports directly to the MHD Director, and the Administrator of the OCA is a member of the Management Team.

- The Consumer Roundtable includes a consumer representative from each RSN who receives public mental health services. Consumers in recovery act as mentors with this group to provide assistance and advice as they assume their role as active participants. This group provides direct input to the MHD Director.
- MHD contracts with two family advocacy groups statewide for education and advocacy purposes. These groups are also very visible during the state's legislative session.
- MHD supports and meets bimonthly with SAFE Washington, a parent council, consisting of parents/caregivers of minor children who receive services through the public mental health system. Each represent a parent organization in their RSN or the Community Connector Project sponsored by the MHD. SAFE Washington provides input to the MHD Director.
- Consumers and family members make-up 51% of our state mental health planning and advisory council (MHPAC). This council (as do all others), includes representatives who are advocates for children and for older adults with mental illness, RSNs, service providers and allied systems. They have worked to recognize service excellence with three awards, one for cross-system, one consumer run and one individual award. They meet 8 times a year and are very active participants in many of the other stakeholder activities and provide valuable input and insight to the MHD.

Other stakeholder work includes:

- MHD staff meet quarterly with the Department of Social and Health Services (DSHS) Indian Policy Advisory Committee (IPAC) to share information and to discuss strengths and concerns.
- MHD and the Division of Alcohol and Substance Abuse (DASA) staff the co-occurring disorders interagency committee (CODIAC) made up of state, providers from mental health, chemical dependency providers, consumers and other cross-system providers. This group has been in existence for approximately twelve years and addresses co-occurring mental illness and substance related disorders.
- MHD staff meets monthly with the RSN administrators and assures that there is representation from the RSNs on any committee, which meets to change, establish or set policy. These committees also include providers, consumers, parents and family advocates. Allied system partners are at times invited to attend. These meetings include topics ranging from performance indicators to Washington Administrative Code changes.
- MHD meets with the Washington Community Mental Health Council (WCMHC) monthly. This is a group representing some of the community mental health agencies providing services under subcontract with the RSNs. The MHD has also developed ways to receive input from the community mental health agencies that do not choose to belong to the WCMHC but subcontract with the RSNs.

Quality Improvement

- As part of the MHD's quality management there have been four separate System Improvement Groups that have met for specific tasks. The System Improvement Group (SIG) is a group of stakeholders representing consumers, parents, family advocates, CMHAs (council and non-council members, Washington Institute for Mental Illness Research and Training (WIMRT), Regional Support Networks and MHD. The group is divided east/west and has no duplicative service area representation.

The first SIG group, SIG 1, met to decide on the major focus areas for RSN/MHD monitoring and system accountability. This group identified three areas of system focus and set outcomes for each. They made recommendations on outcomes and left methodology to achieve each outcome to the responsible entity.

The SIG 2 was formed using the SIG 1 foundation and some of the same individuals for continuity to begin work on the SIG 1 recommendations. SIG 2 defined a pilot project for better coordination of overall monitoring activities (MHD, RSN, CMHC) to reduce duplication of effort. That pilot led to the current realignment of the mental health services section within the MHD to coordinate the activities. As a result of participation on the SIG 2 pilot, consumers and parents are now contractors of the MHD to be an active part of the QA & I team and participate on the annual on-site monitoring.

The SIG 3 group looked further at the deeming process and established working agreements with CARF and JCAHO to recognize deeming thereby further reducing duplicative monitoring activities.

SIG 4 was convened to meet the special term and condition number four on our 1915 (b) mental health waiver modification November 2001 and included a broader group including an advisory committee. This group is charged with developing statewide screening, assessment and authorization into mental health services. This is the group that created the Access to Care Standards. SIG 4 will continue to meet and will be defining standardized elements of screening and assessment.

Other SIG activities may continue to refine additional recommendations using the established SIG foundation and format. SIG recommendations have been incorporated into the MHD's QM plan, planning, policy, and contracting activities.

Stakeholders continue to be an important partner in the data collection and reporting work of the MHD. The Performance Indicator (PI) Workgroup has met monthly to develop the Annual Performance Indicator Report. The PI workgroup includes representatives from the MHD, the RSNs, Community Providers, researchers, consumers of mental health services and parents of children with complex needs.

The RSN have involved stakeholders in a variety of ways including:

Advisory board	Ombuds/QRT
QRT forums	Consumer advisory committee
Support groups	Contracted family organizations
Community forums to gather information and solicit input	Public health agency
NAMI-WA	Housing authority
Chamber of Commerce	Policy workgroups
Quality Management over-site committee	Cross-system committees
DSHS Regional Advisory Committee	Community Hospital
Provider network survey	Allied systems meetings
Tribal meetings and participation	Use of grievance determinations to make broader QM improvements

The community mental health agencies (providers) have involved stakeholders:

Public Health Meetings	NAMI-WA
Allied system meetings	Consumer advisory committee
Clubhouses	Cross-system committee
Consumer and parent voice through direct work	Ombuds/QRT
On boards, committees, forums	Community forums
Washington State coalition for homeless	Civic clubs
Liaison with family groups	Community events to gather information and solicit input

Finally, with the current economic situation in Washington State and the implementation of two new federal administrative regulations, the impacts on the public mental health system are great. Beginning in the summer of 2002 with much stakeholder involvement from the RSNs, the CMHA, consumers, parents and mental health advocates, MHD made difficult choices and developed this waiver modification, the 03-05 biennial contract, and the Quality Strategy. These documents all have their foundation in the work of stakeholders who are committed to persons served by the public mental health system.
Stakeholder work is important to the public system however, in these economic times it may look and feel much different.

Stakeholder involvement in monitoring

Monitoring & evaluation activities are required of the Mental Health Planning and Advisory Council and their subcommittees. This activity is mostly done through communication with their stakeholders and by reading of reports and recommendations. They have hosted three large annual meetings consisting of the entire stakeholder community.

National Alliance for the Mentally Ill (NAMI)-Washington also provides evaluation to the system and provides input to both the MHD and the RSNs. NAMI is also very active in the legislative process at both the state and national level. Their recommendations are used to continue to develop overall system policy and planning and are often blended into the federal block grant application process and into the contract development.

The Consumer Roundtable and SAFE Washington also provide much input to the MHD and the RSNs on the system, its' strengths and weakness.

Additionally, MHD contracts with a consumers and a parent of a minor child receiving service to participate in the on-site monitoring of the Mental Health Division. They have spent this past year developing a survey instrument to collect information on respondent's perceptions of consumer involvement at the RSN level. Questions in the survey are based on the 2001-2003 PHP Review Protocol and corresponding WACs as they refer to consumer involvement. The survey instrument consists of 54 'closed ended' questions in which the respondent is asked to respond to a statement by access to service provider sites, demographic representation, freedom from retaliation, access to

services, ability to resolve complaints, participation in decision making, internal review, and overall support.

Findings of the survey and interviews will be presented in a user-friendly format that will be accessible to a wide audience. Survey response scores will be presented in graph and chart format with brief narratives of what the graphic represents. Quotes taken from the interviews will be interspersed among data findings.

The Mental Health Division believes that all persons enrolled in this waivered program meet the CMS definition of special health care needs. As such, they are considered as part of all stakeholder work.

Over the last ten months, the MHD worked with its partners and stakeholders to complete this modification and draft contract language to be in compliance with the new regulations under 42 CFR 438. As PIHPs there are some changes that will occur in the program and some requirements of the past will be dropped. These changes include the state removing the requirement for disenrollment. There is no alternative fee-for-service system in place and there have been few requests and only one granted disenrollment. The marketing plan, which has been required of the PHP, is being replaced with informing materials produced by the state. Another change that will occur but is purely technical is the change in reference from PCP or Primary Care Provider to Mental Health Care Provider (MHCP) as the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. This is being done, as mental health does not meet the definition of primary care provider in 42 CFR 438.

Regardless of the changes, this modification maintains a system of capitated, managed mental health care which will continue to:

1. Provide comprehensive, integrated mental health services within regionally managed care through Prepaid Inpatient Health Plans;
2. Provide enrollees access to mental health services and active voice in their treatment plan;
3. Provide medically necessary mental health services that are age, cultural and linguistically competent and which are individualized to meet the needs for those enrollees requiring on-going community support;
4. Ensure mental health service intensity is commensurate with each consumer's level of need;
5. Provide rehabilitation and recovery services enabling each consumer to live, work and participate more fully in his/her culture in the community;
6. Provide ready access to crisis services;
7. Ensure engagement and services to high-need populations;
8. Ensure and provide appropriate utilization of community inpatient psychiatric services for adults, older adults, and children in a seamless manner with ongoing care;
9. Participate whenever possible in the coordination of services with other systems of care (e.g., vocational rehabilitation, physical health care, alcohol and substance abuse, acute care, informal and natural support systems, child welfare, juvenile justice, aging and disability services, tribes, corrections, jails, and education); and
10. Promote collaboration with tribal authorities and ensure American Indians access to culturally competent services.

III. General Description of the Waiver Program

a. Type of Delivery Systems: The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PIHP program for a mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.IV.d.1 and Section D.I.

1. ___ **Risk-Comprehensive (fully-capitated—MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

   (a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:
   - i.___ Outpatient hospital services,
   - ii.___ Rural health clinic (RHC) services,
   - iii.___ Federally qualified health clinic (FQHC) services,
   - iv.___ Other laboratory and X-ray services,
   - v.___ Skilled nursing facility (NF) services,
   - vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
   - vii.__ Family planning services,
   - viii.__ Physician services, and
   - ix.___ Home Health services.

   (b)___ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.IV.d.1.

2. _**x**_ **Other Risk (PIHP/PAHP):** Other risk contracts are those that have a scope of risk that is less than comprehensive. The contractors in these programs are either PIHPs or PAHPs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs/PAHPs generally apply to these other risk entities. For PIHPs, please check either (a) or (b); if (b) is chosen, please check the services that apply. For PAHPs, please check (b), and indicate the services that apply.

   (a)___ The contractor is a PIHP at-risk for all inpatient hospital services,

   or

   (b)_**x**_ The contractor is a PIHP or PAHP at-risk for two or fewer of the below services ((i) through (x)).
   - i._**x**_ Outpatient *community mental health rehabilitative services*,
   - ii.___ Rural health clinic (RHC) services,
   - iii.___ Federally qualified health clinic (FQHC) services,

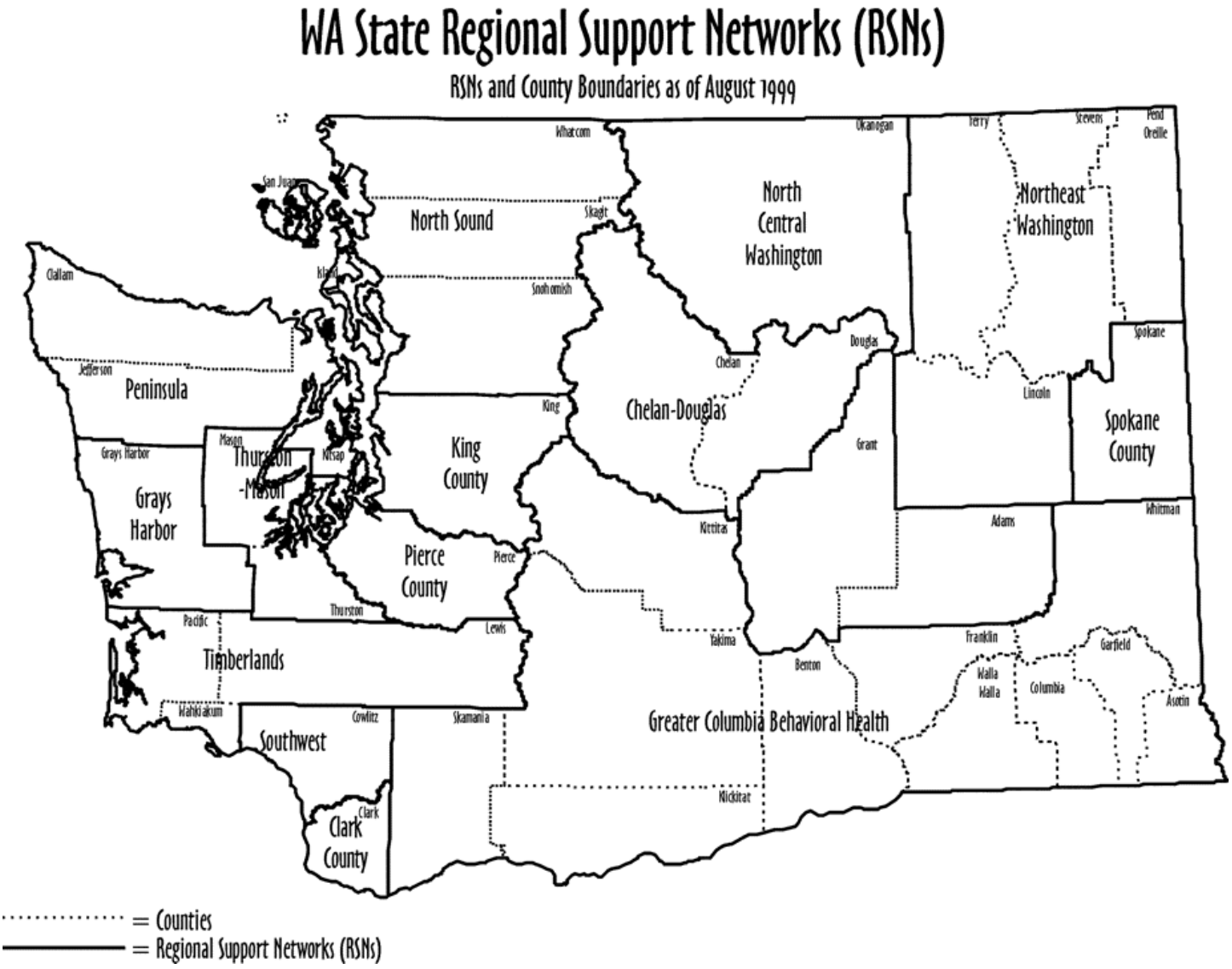
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.___ Family planning services,
viii.__ Physician services
ix.___ Home Health services.
x._**x**_ Other: ___ dental
___ transportation
_**x**_ a subset of *community psychiatric* inpatient hospital services (e.g. only mental health admissions)

3. ___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., a PIHP contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4. ___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

b. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to CMS):

1. _**x**_ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or



2. ___ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, in the chart below please list the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PIHP, PAHP, HIO, or other entity) with which the State will contract:

City/County/Region	Name of Entity* see map above for county	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
	Chelan/ Douglas Regional Support Network	PIHP
	Clark County Regional Support Network	PIHP
	Grays Harbor Regional Support Network	PIHP
	Greater Columbia Behavioral Health Regional Support Network	PIHP

City/County/Region	Name of Entity* see map above for county	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
	King County Regional Support Network	PIHP
	North Central Regional Support Network	PIHP
	Northeast Washington Regional Support Network	PIHP
	North Sound Regional Support Network	PIHP
	Peninsula Regional Support Network	PIHP
	Pierce County Regional Support Network	PIHP
	Southwest Regional Support Network	PIHP
	Spokane Regional Support Network	PIHP
	Thurston Mason Regional Support Network	PIHP
	Timberlands Regional Support Network	PIHP

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

c. Requirement for Choice: Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.

1. ___ This model has a choice of managed care entities.
   - (a)__ At least one MCO and PCCM (please use the combined PCCM Capitated Waiver Renewal Preprint)
   - (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM Waiver Renewal preprint)
   - (c)__ Two or more MCOs
   - (d)__ At least one PIHP or PAHP and a combination of the above entities

2. ___ This model is an HIO.

3. ___ The State is opting to use the exception for rural area residents in Section 1932(a)(3) and 42 CFR 438.52(b). Please list the areas of the State in which the rural exception applies:

4. _**x**_ The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP *for their geographic area*.

d. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. __**x**_ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)
2. __**x**_ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) *except the pregnant women on the family planning only program. Program code S, medical code P and Z.*
3. __**x**_ Blind/Disabled Children and Related Populations (SSI)
4. __**x**_ Blind/Disabled Adults and Related Populations (SSI)
5. __**x**_ Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.) Includes SSI, QMB

Plus, and Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2).

6.__**x**_ Foster Care Children

7.__**x**_ Title XXI SCHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9.___ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

(a) ___Children with special needs due to physical and/ or mental illnesses,
(b) ___Older adults,
(c) ___Foster care children,
(d) ___Homeless individuals,
(e) _**x**_Individuals with serious and persistent mental illness ~~and/or substance abuse~~,
(f) ___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
(g) __ Other (please list):

Please see Attachment A.III.d. for Access to Care Standards and minimum eligibility criteria. The MHD was required to develop statewide screening, assessment, and authorization as a special term and condition on our last waiver renewal. This criterion is to be tested and refined. As this modification is required before that project is complete, this document may continue to evolve. MHD will submit the progress report due in November 2003.

The PIHPs are expected to meet the mental health needs of the consumers they serve. They are encouraged to provide more innovative and flexible supports. All services are to be provided by a network that is licensed and or certified by the state. All services are to be provided by or under the supervision of a mental health professional.

The MHD wishes to exercise its rights as described by CMS at the Regional Training in Seattle and Baltimore and amend the definition in 438.2 of Health Care Professional. In addition to the definition specified 438.2, the MHD requests the definition be expanded to include Mental Health Professional and mental health specialists as described in Washington Administrative Code (WAC) 388-85-0150, or its successor under this waiver. The WAC and the Revised Code(s) of Washington (RCW) are attached as Exhibit A. This will allow the public mental health system to continue to have qualified staff perform authorization to mental health service, second opinion, grievance and appeal functions appropriate to their scope of practice and experience and allow the effective use of mental health professionals **Primary Care** definition is not applicable to mental health.

Mental Health Care Provider (MHCP) means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services.

Provider *for this waiver modification is a Community Mental Health Agency (CMHA)*

Intensity *for this waiver modification is the same as Duration and Scope. CMS staff defines duration as the period of time and scope to mean the range of services (e.g. which state plan services an individual would receive if offered in a fee-for-service system.*

Amount *is defined by CMS staff as the number of sessions.*

Availability of providers *per CMS staff is defined as meaning enough present*

Adequate capacity *per CMS staff means that the provider can handle the volume or meet the demand*

Attachment A.III.d.

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization *	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 51 – 60.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization *	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 51 - 60.</u>** **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 04/07/03
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following guidelines reflect the most restrictive eligibility criteria that can be applied RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.. <u>The guidelines are not intended to be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports * The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
5-28-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility criteria for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility. RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness

* Two or more hospital admissions due to a mental health diagnosis during the previous two years

* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months

duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization

* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
5-28-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility criteria for Medicaid Children & Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage. RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	Psychotic Features	
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.
[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness

- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.

- Two or more hospital admissions due to a mental health diagnosis during the previous two years

- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization

- Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

- Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:

    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers)
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability

to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

End of Attachment A.III.d.

e. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. _**x**_ Have Medicare coverage, except for purposes of Medicaid-only services;
2. ___ Have medical insurance other than Medicaid;
3. ___ are residing in a nursing facility;
4. _**x**_ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);
5. ___ are enrolled in another Medicaid managed care program;
6. ___ have an eligibility period that is less than 3 months;
7. _**x**_ are in a poverty level eligibility category for pregnant women *with family planning only program code S, medical code P and Z.*;
8. ___ are American Indian or Alaskan Native;
9. ___ participate in a home and community-based waiver;
10. __ receive services through the State's Title XXI CHIP program;
11. __ have an eligibility period that is only retroactive;
12. __ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in l. above are listed here (Please explain further in Section F. Special Populations if necessary);
    (a) ___Children with special needs due to physical and/ or mental illnesses,
    (b) ___Older adults,
    (c) ___Foster care children,
    (d) _x__Homeless individuals *for whom no Medicaid reimbursement is received*,
    (e) ___Individuals with serious and persistent mental illness and/or substance abuse,
    (f) ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
    (g) __ Other (please list):
13. _**x**_ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below: Residents of State psychiatric hospitals, persons enrolled in the PACE program and the Children Long Term Inpatient Program are excluded from the capitation system and paid through other means.

f. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

g. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. ___ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.

2. _**x**_ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

IV. Program Impact

In the following informational sections, please complete the required information to describe your program.

a. Marketing including indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). *Information to potential enrollees and enrollees (i.e., member handbooks), is addressed in Section H.*

Previous Waiver Period

1. ___ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

   In the past, CMS has required the MHD to require marketing plans from the PHPs on a biennial basis. These plans were submitted by the PHP and approved by the MHD. Included in those plans were brochures informing consumers about RSN/PHP service. They however, were not in the detail required under this regulation. The MHD is assuming the responsibility for distribution of informing materials. There will be no requirement on the PIHP for marketing activity. The brochures required under Condition 1 of the current waiver modification on September 30, 2003 to be submitted CMS will not be required.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period.

Per the Seattle and Baltimore training offered by CMS, Section 438.104 is not applicable to the system where enrollment is mandatory for all Medicaid enrolled persons into a single plan and

there is no process used to influence membership.

1.___ The State does not permit direct or indirect MCO//PIHP/PAHP marketing (go to item "b. Enrollment/Disenrollment")

2.___ The State permits indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general). Please list types of indirect marketing permitted.

3.___ The State permits direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5.___ The State permits MCOs/PIHP/PAHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check those that apply):

(a) __ The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.

(b)__ The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately ___ percent or more of the population.

(c)__ Other (please explain):

7.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **Required Marketing Elements**: Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.

The State:

(a)___ Ensures that all marketing materials are prior approved by the State

(b)___ Ensures that marketing materials do not contain false or misleading information

(c)___ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials

(d)___ Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service

area

(e)___ Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)___ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g)___ Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements. Please include the results from those monitoring efforts for the previous waiver period. (Reference items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint; items A.III.b Upcoming Waiver Period of 9/23/99 Waiver Renewal).

   The state will put previous waiver language. If no language, state that this does not apply. During this current waiver period, as in the past, the MHD has staff assigned to oversee disenrollments. Our historical experience leads us to believe the number of disenrollment requests is small because consumers may change MHCP or even to go to another community mental health agency without requesting disenrollment. The RSNs contract with a variety of community mental health agencies within their service area. These community mental health agencies employ a number of persons who act as mental health care providers. The WAC defines a primary care provider as the person who is responsible to carry out the individualized service plan. (This definition will be amended to mental health care provider as the Primary Care Provider definition in the regulation is not applicable to our program,)If the enrollee is assigned case manager, that case manager is the primary care provider. The MHD does not track these requests for change. Grievances or complaints regarding a consumer's inability to transfer to another provider would be reported as part of the grievance, fair hearing report process and may come to the attention of the MHD. As a result of the stakeholder work and the fact there has been no disenrollment requests in the last two years the MHD is seeking waiver to disenrollment.

   Enrollment is mandatory in our program.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PIHPs/PAHPs by checking the applicable items below.

The state requests the authority to waive requirements related to disenrollment under 438.56. The MHD is removing the disenrollment right in this waiver modification. Per the training in Seattle, the program operated by the MHD does not have to offer disenrollment. And based on the ten years that we have operated the waiver, there has been a very small number of requests and only one approval.

There is currently no alternative fee-for-service system available. The state's benefit notice to consumers includes their rights to fair hearing, to grieve, etc.

1. ___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2.___ **Administration of Enrollment Process**:

(a)___ State staff conduct the enrollment process.

(b)___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _____

ii. Procurement method:

(A). ____Competitive

(B). ____Sole source

iii. Please list the functions that the contractor will perform:

(c)___ State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_**x**_ Mandatory for populations in Section A.III.d.

(b)___ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4**.** **Enrollment:**

(a)___ The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)___ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs/PAHPs and providers based on their medical needs. Please describe.

(c)___ Enrollees will notify the State/enrollment broker of their choice of plan by:

i. ___ mail

ii.___ phone

iii.___ in person at ____

iv.___ other (please describe):

(d)__NA_ mandatory enrollment [Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

(e)___ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)___ If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.

ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?

(h)___ The State provides guaranteed eligibility of ____ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)___ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)___ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.

i. ___ Enrollee submits request to State

ii. ___ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State plan may not disapprove the request).

iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP grievance procedure before determination will be made on disenrollment request

iv. ___ [Required] Regardless of whether plan or State makes determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

(b)_**x**_ The State does not allow enrollees to disenroll from the only available PIHP/PAHP.

(c)___ The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:

(d)___ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.

ii.___ MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO/PIHP/PAHP enrollees who have the following good cause reasons for disenrollment are allowed to disenroll during the lock-in period:

A.___ [Required] Enrollee moves out of plan area

B.___ [Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks

C.___ [Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk

D.___ [Required] Poor quality of care

E.___ [Required] Lack of access to covered services

F.___ [Required] Lack of access to providers experienced in dealing with enrollee's health care needs

G.___ Other: (please list)

iv.___ [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.

(e)___ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.

(f)___ [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PIHP/PAHP.

6. **MCO/PIHP/PAHP Disenrollment of Enrollees**: If the State permits MCOs/PIHPs/PAHPs to request disenrollment of enrollees, please check items below that apply:

(a)___ [Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:

(b)___ The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.

(c)___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP to remove the enrollee from its membership.

(d)___ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

c. Entity Type Or Specific Waiver Requirements

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period.

1._**x**_ **Required MCO/PIHP/PAHP Elements:** MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq. *Unless waived*

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting authority under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a)_**x**_ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i._**x**_ Although the organization of the service delivery and payment mechanism for that *mental health* service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan. *This is not different from the current system but is different from the fee-for- system. State plan services are attached as Attachment A.IV.c.2.a.i. At the time of this waiver modification the MHD was awaiting approval on changes.*

ii._**x**_ MCO/PIHP/PAHP must provide or arrange to provide for the full range of Medicaid *mental health* services to be provided under the waiver *when medically necessary.*

iii._**x**_ MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full *for those services covered by the mental health division.*

iv. ___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.
State psychiatric hospital, persons who are enrolled in PACE and CLIP residents are excluded from the waiver**.** Nursing home residents needing medically necessary mental health services can change MHCP/CMHA as can any enrollee. They remain enrolled in the PIHP.

v._**x**_ There are no restrictions that discriminate among classes of ~~providers~~ CMHA on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

Attachment A.IV.c.2.a.i.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Washington

7.Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to serious mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. Payment rates are established per Attachment 4.19-B XVIII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis Hotline
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Residential treatment;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

A. Definition of medical necessity as it relates to mental health services

Medical necessity or **medically necessary** – "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need".

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902.A.23.

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

Mental health professional means:

"(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265".

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Psychologist" means a person licensed as a psychologist by the state.

"**Mental Health Care Provider"** means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

"Peer Counselor" means the individual who has self identified as a consumer or survivor of mental health services, has received specialized training, passed a written/oral test, a background test been certified by the Mental Health Division and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services.

Peer Counselors must demonstrate:
That they are well grounded in their own recovery for at least one year;
Willingness to a pretest for reading comprehension and language composition; and,
Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

Peer Counselors must be able to:

- identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;
- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings, and
- Model competency in recovery and ongoing coping skills.

Peer Counselors must receive a minimum of 40 hours of training provided/contracted by the MHD, and pass a test, which includes both written and oral components of the training. Peer Counselor must also pass a Washington State background check, be willing to disclose they are a former or current consumer of mental health services, and be certified by the Department of Health as a registered counselor.

Training shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system
- What is peer support and how it promotes recovery
- How to advocate for age appropriate peer support projects
- How to facilitate groups and teams
- Understanding self-directed recovery
- How to create your own self-help coping skills plan
- How to start and sustain self-help/mutual support groups
- How to form an sustain a personal support team
- How to promote recovery, self-determination and community ~~living~~. reintegration
- Assist consumers to do for themselves and each other.
- Assist in skill building, goal setting, problem solving,
- Assist consumers to build their own self-directed recovery tools
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

Peer Counselors who were trained prior to the implementation of the WAC by National Consultants to be Certified facilitators who pass the test and the background check may be grandfathered as Peer Counselors until January 2005. After January 2005, it will be necessary for them to take the training.

Staff Supervision- means the person(s) having the responsibility for regular/periodic clinical oversight of other staff providing direct mental health services to consumers. Supervision includes an independent judgement to assist another clinical person to adjust, reward, direct, recommend on the treatment of a client. Supervision is not routine it is individualized to the client and staff.

B. Definitions

1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

2) Crisis Hotline: telephone service provided by trained personnel and supervised by mental health professionals which includes triage, referral and telephone based support to Medicaid enrolled individuals experiencing a mental health crisis. Crisis hotlines operate on a 24-hour basis. This service will be accessed via a toll free number assigned only to Medicaid clients. Crisis Hotline services may be provided without intake evaluation for mental health services. The state will assure that policies and procedures are in place, Medicaid enrollees are identified, resolution of the crisis is assured, and necessary ongoing treatment occurs.

3) Crisis Services: evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

4) Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their essential activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day 4 days per week.

5) Family Treatment: Counseling provided for the direct benefit of a Medicaid enrolled individual. Service activities are provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment is intended to benefit the client to obtain reintegration and recovery into the community. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals

identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

6) "Freestanding Evaluation and Treatment" Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond seventeen days.

7) Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:20. Maximum group size is 40.

8) High Intensity Treatment: Intensive treatment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available during extended hours. The team consists of the consumer, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the consumer (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers, teacher, minister, physician, chemical dependency counselor, etc. Team members work together to provide intensive treatment as described in the individual service plan. The team also has the ability to promptly asses, re-assess and modify the individual service plan if the need arises. The team closely monitors symptoms and provides immediate feedback to the individual and to other team members. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. Services provided by the mental health professionals, mental health care providers and Peer Counselors shall be billable to Medicaid. The staff to consumer ratio for this service is no more than 1:15.

9) Individual Treatment Services: a set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling

and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

10) Intake Evaluation: an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, crisis hotline services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. This service is provided by or under the supervision of a mental health professional.

11) Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

12) Medication Monitoring: Face to face cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

13) Mental Health Residential Treatment: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments, adult family homes) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, nursing, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is only billable for a maximum of 16 hours per day per consumer. This service does not include the costs for room and board and medical services and differs from other services in terms of location and duration.

14) Peer Support: Services provided by certified Peer Counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. These services may include for Medicaid enrollees, self-help support groups, telephone support lines, drop-in centers, and engaging activities to locations where consumers are known to gather. Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility. This includes locations such as churches, parks, community centers. etc. Services are geared toward consumers with severe and persistent mental illness. Consumers actively participate in decision-making and the operation of the programmatic supports.

Services provided by Peer Counselors to the consumer are noted in the consumers' Individualized Service Plan delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment

goals have not yet been achieved.

Peer Counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

These services will not be billed until the peer counselors have passed all the requirements and are registered with the Department of Health.

15) Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

16) Rehabilitation Case Management: a range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement and to minimize the risk of unplanned readmission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

17) Special Population Evaluation: evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

18) Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

19) Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics;

medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

End of Attachment A.IV.c.2.a.i

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:

   (a)___ The State has used/will use a competitive procurement process. Please describe.

   (b)___ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

   (c)_**x**_ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

   The MHD is requesting a waiver to Section 438.52. For the reasons outlined above the first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts is provided to county-based Regional Support Networks. Contracts are entered into and maintained according to state statute governing Government to Government contracts.

   If an RSN chooses not to participate in this initiative, or is unable to meet required qualifications, the MHD will secure an alternate contractor through appropriate means.

   The Department of Social and Health Services will retain its administrative authority as the single state agency and makes no inappropriate delegation.

4._**x**_ Per Section 1932(d) of the Act and 42 CFR 438.58, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO/PIHP/PAHP contracts and the default enrollment process established for MCOs/PIHPs/PAHPs.

d. Services

Previous Waiver Period

1._**x**_ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with *mental health* service provision requirements. Please include the results from those monitoring efforts for the previous waiver period. [Reference: items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d. Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

PIHPs are required to provide services comparable in scope and intensity to the fee-for-service state plan rehabilitation services and community inpatient services for adults and children. PIHPs must also ensure system capacity to provide a full range of mental health services to the individual enrollee's needs in a way that provides for seamless coordination and continuity of services. These mental health services should provide for the least amount of disruption in the consumer's life and support recovery and community reintegration.

The MHD monitors services in a variety of ways. In addition to the annual on-site monitoring activities of the QA & I section, there are the meetings with stakeholders as described, additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys. QA & I report that services are generally within the acceptable standards. Acceptable standards are 90% score on the respective licensing sections and WAC requirements. Licensing and monitoring tools detailing MHD criteria have been provided and explained to CMS. All reports have been forwarded to CMS. The Performance Indicator report is in Exhibit B. Work on the Performance Indicators continues to evolve with SAMHSA and the President's Task Force on Mental Health and definitions set and modified. Trends can not be established until the third year of data is complete. However, the report with careful attention to the data notes can begin to show comparison of an RSN one year against the next. This report is not intended to compare RSNs against each other.

Results of consumer surveys conducted over the renewal period show that seventy-eight percent of the participants said they were mostly or very satisfied with the Quality and Appropriateness of their mental health services. Female participants and those participants between the ages of 18 and 21 years of age demonstrated a higher level of satisfaction. No statistically significant differences occurred among ethnic minorities. Seventy-eight percent of the participants said they were mostly or very satisfied with access to mental health services. Those who were 60-75 years of age had higher satisfaction with access than did those 21-40 years of age. No statistically significant differences occurred among different genders or ethnic minorities.

Two child and family surveys have been completed. The first was sent to CMS. The second will be available soon after this modification is due and will be forwarded to CMS.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period.

1._**x**_ The Medicaid services MCOs/PIHPs/PAHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are or are not in the MCO/PIHP/PAHP contract; which non-covered services are impacted by the MCO/PIHP/PAHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new non-state plan services are available only through the MCO/PIHP/PAHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PIHP/PAHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PIHP/PAHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PIHP/PAHP, i.e. not included in the reimbursement paid to the MCO/PIHP/PAHP. However, do not include services impacted by the MCO/PIHP/PAHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PIHP/PAHP: Check this column if the service is not the responsibility of the MCO/PIHP/PAHP, but is impacted by it. For example, if the MCO/PIHP/PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PIHP/PAHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PIHP/PAHP (see column 5).

*For this modification, the chart reflects current cost-effectiveness and will be updated during the conversion waiver due March 4, 2004. The services required in the contract for August 1, 2003 reflect changes in the State Plan amendment and will be reflected in this chart in the conversion waiver.

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Crisis *mental health* Services	✓		✓		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
EPSDT *mental health*	✓		✓		
Federally Qualified Health Center Services					
Inpatient Hospital – Psychiatric	✓		✓		
Lab					✓
Mental Health Services	✓		✓		
Pharmacy					✓
Physician					✓
Psychologist Assessment	✓				
Substance Abuse Treatment Services					
Transportation – Emergency					✓
Transportation - Non-emergency					✓

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

   (a)___ The State has a more stringent definition of emergency medical condition for MCOs/PIHPs/PAHPs. than the definition above. Please describe.

   The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain. See above

   (b)___ The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)___ The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*

i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.___ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.___ Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

iv.___ Continued emergency services until the enrollee can be safely discharged or transferred,

v.___ Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

(d) The State also assures the following additional requirements are met:

i.___ The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;

ii.___ The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PCP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

iii.___ The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO/PIHP/PAHP.

(e)_**x**_ The MCO/PIHP/PAHP does not cover emergency services.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PIHP/PAHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

Not applicable under this waiver

(a)___ Enrollees are informed that family planning services will not be restricted under the waiver.

(b)___ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PIHP/PAHP will be required to reimburse non-network family

planning services

ii.___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___ The State will pay for all family planning services, provided by both network as well as non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) _**x**_ Family planning services are not included under the waiver.

4. **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PIHPs/PAHPs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following services: Not applicable under this waiver.

(a)___ [Required for rural exception to choice]

- The service or type of provider is not available in the plan;
- for up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
- MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.

(b)___ [Required if women's routine and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)

(c)_**x**_Other: (please identify)

Each PIHP has an integrated crisis system, which is accessible 24 hours/7days a week with responses, which are from individuals, rather than recorded messages. The intent is to facilitate efficient and effective mental health crisis diversion and resolution; to resolve crises in the least restrictive manner possible, including: crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services. These services are available throughout the PIHP, including for American Indians living on or off Indian reservations.

Phone systems must continue to have toll free numbers to ensure access to crisis services, including people who may not have the funds to utilize a public pay phone. If these numbers are not toll free but accept collect charges it must be stated so in the public telephone directory. Services for non-English speaking and hearing impaired enrollees must also be in place.

While crisis response services from PIHPs are covered within the scope of the managed care system, enrollees access to crisis response is unrestricted, without establishing medical necessity for the first contact and without reference to the enrollee's ongoing service coverage under a particular RSN. PIHPs triage with local hospitals to reduce unnecessary utilization of emer-

gency rooms through the working agreements with local evaluation and treatment facilities, which are a necessary qualification of PIHPs. The agreements assure that enrollees who request mental health services inappropriately from emergency rooms are directed to the crisis response system. The agreements also establish how people served in emergency rooms may be referred for County Designated Mental Health Professional evaluation for possible involuntary treatment. Emergency room visits not resulting in admission are not covered by this waiver, but as part of the fee-for-service program in MAA. Inpatient services for enrollees admitted through the emergency room are covered provided the designated professional person for the consumer(s) county of residence has conducted a pre-admission certification and conditions of medical necessity are met.

5.___ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PIHP/PAHP to track, coordinate, and monitor services to which an enrollee can self-refer:

PIHPs are required to report through the MHD/CIS system crisis services MHD calls out access to care standards with regards to transition from crisis service to routine service. For those clients already seen by the CMHA, WAC requires access to the clients individual service plan 24/7. Additionally, crisis phone services must be available to Limited English Speaking People. The crisis system is also mandated to be accessible for American Indian's living on the reservation. The crisis system is an integral piece of the system and is monitored by the MHD and the PIHPs routinely.

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP is not required to provide FQHC services to the enrollee during the enrollment period.

(b)_**x**_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP/PAHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP with a participating FQHC:

Currently there are FQHCs contracting for mental health services in the public mental health system and will continue participating in the waiver system if they so choose. The PIHPs are required to contract with at least one FQHC in their service area if the FQHC requests. The FQHC is accessed the same as any other CMHA in the RSN service area.

(c)___ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a)_**x**_ The State requires MCOs/PIHPs/PAHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

Washington State has had an approved EPSDT Plan since 1992. Children covered under EPSDT receive the same mental health services as other children. However, given the same clinical need, the child referred through EPSDT screening will receive the first appointment. The plan includes preventive screening and cross-system team planning. This team planning also includes the child and their family. In the mental health system, in the early 90s it was projected that there would be a large influx of children to the system and a special EPSDT flag was established in the data dictionary. While this increase was true of some of our sister agencies, it was found that the mental health system was already seeing these children. We still require a data flag for children referred to mental health through EPSDT or for those children in the mental health system who are referred to the physical health care programs for a check-up per the periodicity schedule, to the dentist or to substance abuse. We do not however, limit admission to the system to only children referred under EPSDT. Any child meeting the medically necessary definition for mental health services is served.

One initial requirement contained in our original EPSDT implementation that continues today is correspondence and follow-up with physicians or other referral sources for children with EPSDT screens. The Community mental health agencies continue to notify the physician or other referral source when they have seen a child referred and provides information on what service(s) will be offered. This follow-up activity was found to be one of the most influential and helpful activities to increase communication between physical and mental health care for these children. This correspondence loop has also provided for better access to physical health care for the children who are seen initially in the mental health system.

The PIHPs are required to submit the data as they would for any child being served according to the requirements of the data dictionary attached as Attachment C.VI.b. There is simply a data flag if the child is referred in through an EPSDT screen. Of the 29,521 children served in the outpatient mental health system during CY2002, there were 6,994 unduplicated consumers flagged as being referred to mental health services through an EPSDT screen. This may be an under reporting of the actual numbers. This is a mandatory data field and when it is submitted unfilled or not 'Yes' or 'No', the EPSDT value is defaulted is no.

(b)___ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual

screening rates, including behavioral components, for previous waiver period. (Please note*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c)___ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d)___ Immunizations are covered under this waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)__x_Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

The requirement for those individual community teams including the child for the development of service planning for 10% of the children defined in the state's EPSDT plan as level II also requires participation by the cross-system providers. This process includes those who know the child best including the teacher whenever possible to address IEP and other requirements. There is also a requirement in the WAC 388-865-0425 with regards to Individual Service Planning that there be connection to the IFSP.

(f)_xMechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PIHP/PAHP. Please describe.
If a child is being seen by the mental health system or comes through the doors of the mental health system as their first access point, and in need of other health services such as a well child check per the periodicity schedule or the child is in need of dental or substance abuse counseling they are referred to the proper provider of care. Mental Health PIHPs do not provide that type of care. There is a well established referral process between mental health and physical health that in a recent survey by the state was acknowledged by both professions and making a difference in the working relationship of the two system with regards to the holistic care of children.

Section B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residences of the enrollees in the program.

Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Timely Access Standards

Upcoming Waiver Period -- Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients' normal means of transportation, for MCO/PIHP/PAHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6._**x**_ Mental Health (please describe your standard):

While it is still the belief that consumers should be seen in the place of their choice for community support services, the state recognizes that at times they must travel to community support services. When this occurs the following standards are in place:

- ✓ in rural areas a 30 minute drive time
- ✓ in large rural areas a 90 minute drive time
- ✓ in urban areas, accessible by public transportation. The total trip including transfers shall not be scheduled to exceed 90 minutes each way

The exceptions to these standards identified in the contract are if a consumer chooses to seek services from a community mental health agency that is farther than the drive time or there are hazardous road conditions, road construction, traffic congestion, public transportation shortages, ferry or bus delay etc.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

b. **Appointment Scheduling** (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PIHP/PAHP enrollee's access to the following. Check

any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6._**x**_ Mental Health (please describe your standard):

Enrollees can access medically necessary mental health services upon request that do not exceed the access standards below. A request for services is defined as a point in time when services are sought or applied for through a telephone call, referral, walk-in, or written request for services. Urgent and Emergent medically necessary mental health services (e.g. crisis services, stabilization services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.

An intake assessment is initiated within 10 working days of the request for services.

Routine mental health services are offered to occur within 14 calendar days of completion of intake.

Emergent mental health services occur within 2 hours of the request for services from any source.

Urgent care occurs within 24 hours of the request for services from any source.

An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA if: a) the Contractor provides written justification to the MHD regarding the need for additional information; and b) the Contractor indicates how the extension is in the consumer's best interest**.**

The following are the contract definitions:

Emergent Care: service provided for a person that, if not provided, would likely result in the need crisis intervention or for hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Urgent Care: To be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Routine Care: A setting where evaluation and mental health services are provided to consumers on a regular basis. These services are intended to stabilized, sustain, and facilitate consumer recovery within his or her living situation and they do not meet the definition of urgent or emergent care.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Urgent care (please describe your standard):

10.___Other providers (please describe your standard):

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6._**x**_ Mental Health (please describe your standard):

For those services that do occur in the office the wait time for a consumer should be minimal. There are times when it may be necessary and acceptable for a consumer to wait however, a consumer should not have to wait for over an hour beyond the scheduled appointment time.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

II. Access and Availability Monitoring: Enrollee access to care will be monitored by the State, as part of each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

Previous Waiver Period

a._x_[Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint; item B.II Upcoming Waiver Period, 9/23/99 Waiver Renewal Preprint].

As stated in our previous renewal, the standards called out were new and would be monitored over the course of the waiver by spot checks of the QA & I Team's on-site visits and adjusted accordingly. To

be compliant with the new regulations, this waiver modification is six-months earlier than scheduled therefore the review is still ongoing and final decisions have not been reached.

The minimum Access to Care standards and minimum eligibility criteria will be in place beginning in July 2003 for use. The PIHPs Level of Care guidelines are submitted to and approved by the MHD within 90 days of contract execution. Level of Care guidelines must include length of stay and discharge criteria. As at risk contractors, this must be left to the PIHP.

Please see Exhibit B for data for service utilization for FY 01 and FY 02. The changes in service hours for FY 02 are the results of the data dictionary change that allows for more data to be captured.

Please note that there may be variance in the number of Medicaid persons reported within the documents supporting this modification. There are two methods used by the Mental Health Division (MHD) to calculate the number of people who are enrolled for Medicaid funded mental health services within a fiscal year.

One method is used by the MHD's Fiscal section and another is used by the Information System (IS) section. Using data sent to them by MAA, the IS Section adds up the number of unduplicated PIC codes across the 12 months in the fiscal year. This calculation method results in a count of the number of unduplicated PIC codes in a fiscal year. Although this procedure does not provide an unduplicated count of people (in error a person may be assigned more than one PIC code), it does provide an unduplicated count of PIC codes. Because this count represents unduplicated PIC codes, and not people, it is likely that the count provided by the IS department is slightly inflated.
Using the same data provided by MAA, the Fiscal department adds up the number of PIC codes served each month within the fiscal year and then divides this number by 12. This method result in the average monthly number of people who are enrolled for Medicaid funded mental health services. This number most likely provides an undercount of the number of people who are enrolled for Medicaid funded mental health services in a fiscal year.

In addition to the two methods outlined above, MAA often calculates the number of Medicaid enrolled. We are currently in the process of trying to determine how MAA calculates their fiscal year totals. MHD stops adjusting their fiscal numbers after a six-month period of time, MAA however, continuously updates and changes their monthly numbers.

MHD has made the decision for most reporting, we will use the fiscal method of reporting and provide data notes explaining any change in this policy.

Upcoming Waiver Period -- Check below any of the following (a-o) that the State will also utilize to monitor access:

a.___Measurement of access to services during and after a MCO/PIHP/PAHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

b._x_Determination of enrollee knowledge on the use of managed care programs *through involvement with the Office of Consumer Affairs, the Roundtable, through SAFE Washington, the MHPAC and the*

contracted consumer positions of QA & I.

c._x_Ensure that *mental health* services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner.

d.___Review of access to emergency or family planning services without prior authorization

e.___Review of denials of referral requests

f.___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g._x_Periodic enrollee ~~experience~~ *MHSIP consumer* surveys *for both adults and child/family* (which includes questions concerning the enrollees' access to all services covered under the waiver *is conducted using a Consumer Assisted Telephone Interview System (CATI).* ~~) will be mailed to a sample of enrollees~~. ~~Corrective actions taken on deficiencies found are also planned.~~ *RSNs satisfaction will be compared against their own results and not statewide. They are expected to maintain or improve their results.*

h.___Measurement of enrollee requests for disenrollment from a MCO/PIHP/PAHP due to access issues

i._x_Tracking of ~~complaints/~~grievances concerning access issues

j.___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k.___Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. During monitoring, the State will look for the following indications of access problems.

1.___ Long waiting periods to obtain services from a PCP.

2.___ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.

3.___ Enrollee confusion about how to obtain services not covered under the waiver.

4.___ Lack of access to services after PCP's regular office hours.

5.___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

6.___ Lack of access to emergency or family planning services.

7.___ Frequent recipient requests to change a specific PCP.

8.___ Other indications (please describe):

m.__Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient,

medically necessary mental health services.

n._x_ Monitoring the ~~provider~~ *CMHA* network showing that there will be providers within the distance/travel times standards *per the availability standards described*.

Ensure that when enrollees must travel to service sites, they are accessible per the following standards: 1) in rural areas, service sites are within a 30-minute commute time; 2) in large rural geographic areas service sites are accessible within a 90-minute commute time; 3) in urban areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90 minutes each way;

Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) to psychiatric inpatient services; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service). (MHD standards per RCW 71.24)

o.___ The incentives, sanctions, and enforcement related to the access and availability standards above.

p.___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a._x_[Required] MCO/PIHP/PAHP Capacity Standards. The State ensured that the number of ~~providers~~ *Community Mental Health Agencies* under the waiver remained adequate to assure access to all services covered under the contract. Please describe the results of this monitoring.

The PIHP contracts with licensed CMHAs for the provision of mental health services. The MHD is the licensor of CMHA and also certifies inpatient beds for involuntary treatment. The number of CMHAs providing services has remained fairly consistent throughout the waiver since 1993. There have been some mergers or sales in the outpatient system but this has not reduced overall capacity. The MHD has licensed five new CMHAs over the course of this waiver modification period.

Since the PIHP serves a specific geographic area, the MHD requires assurances from each PIHP that they will guarantee a sufficient number of service sites, both in and out of facility, to assure enrollees have convenient access to service locations as expressed in the availability standards. In addition, under the rehabilitation services options, most services, especially crisis services, are provided out of the facility (e.g., enrollee's residence or in other community settings that are comfortable to the enrollee). The MHD assures that adequate service capacity and service diversity can be met through the integrated community mental health program. Please see the geographic capacity of the PIHP attached as Attachment B.III.a.

The PIHP will continue to provide inpatient service through community psychiatric inpatient hospitals and will purchase service capacity for adults and children to ensure that services are as close to the enrollee's community as possible so long as it is clinically indicated. The contract with the PIHP

stipulates that resource management of acute inpatient care shall be performed under the general oversight of a physician. A physician must review any denial of a request for voluntary inpatient authorization.

The state (MAA) contracts with hospitals that are licensed and willing to provide inpatient psychiatric care. The continued reduction in the general community psychiatric inpatient beds has had impact upon the immediate availability of beds, at times resulting in consumers being placed far from their homes, or being diverted to non-inpatient services. This appears to be especially true for children's inpatient beds.

The overall long-term impact of the loss of community psychiatric inpatient hospital beds is a national trend and continues to be difficult to predict. The MHD and the PIHPs are carefully watching capacity. Nonetheless, existing community inpatient psychiatric hospital providers are in very tenuous financial situations, often with little support from their corporate structures.

Some PIHPs have, or are attempting to build alternative resources. Existing Evaluation and Treatment (E&T) facilities are designed specifically to meet some of the need. However, E&Ts are likely to feel additional pressure to expand if community psychiatric hospital beds are reduced further. This continues to put a drain on state funds as the E & T facilities are not recognized by CMS as an inpatient facility and all room and board costs must be paid out of state funds for Medicaid consumers. We are requesting that CMS continue to work with the MHD on this issue because this resource for a Medicaid enrollee may no longer be available.

The state will allow the PIHPs to submit a regional plan for direct contracting with psychiatric hospital providers. Any contract between a PIHP and local hospital must contain the provision of collaboration for emergency admissions to non-contracted hospitals and the transfer of enrollees to contracted hospitals. The state allows exceptions to this, if the transfer would cause harm to the enrollee, or there is no psychiatric hospital unit within reasonable travel time of the residence of the immediate family member who helps with the personal needs of the enrollee. Each PIHP needs to ensure that Medicaid enrollees who have other insurance but have exhausted their benefits will receive continuity of care.

Any PIHP that develops a direct psychiatric hospital contract network will be required to develop a plan that ensures hospitals and physicians will be provided orientation to the prepaid inpatient health plan. All contracts between a PIHP and community hospital will have a grievance procedure for enrollees, which will be made available to enrollees. If a PIHP develops a direct contract network, the state will require them to show that they have a capacity (combined in-network and out-of network providers) of at least 110% of their actual utilization for the prior year. The plan must be submitted to the MHD 90 days in advance for approval.

Attachment B.III.a.

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
Chelan Douglas RSN							
Children's Home Society	Wenatchee, East Wenatchee, Chelan, Waterville, Bridgeport, Orondo, Leavenworth, Cashmere, Manson, Monitor, Entiat, Molega, Rock Island, Pasisades.	7:452	5 child 1 geriatric		Capacity is expanded as necessary to meet the needs of the population served.	2	0
Catholic Family & Child Service	Wenatchee, East Wenatchee, Chelan, Waterville, Bridgeport, Orondo, Leavenworth, Cashmere, Manson, Monitor, Entiat, Molega, Rock Island, Pasisades.	10:383	2 child 1 minority		Capacity is expanded as necessary to meet the needs of the population served.	3	2
Chelan-Douglas Behavioral Health Clinic	Wenatchee, East Wenatchee, Chelan, Waterville, Bridgeport, Orondo, Leavenworth, Cashmere, Manson, Monitor, Entiat, Molega, Rock Island, Pasisades.	35:2249	3 geriatric 2 child 2 minority 1 DD 7 CDMHP		Capacity is expanded as necessary to meet the needs of the population served.	3	0
Clark RSN							
Columbia River Mental Health Services – Provides a full range of mental health services, including residential programs, day treatment programs, crisis services/out reach to special populations, employment services, case management, intensive case management, and COD for adults. - Provides range of mental health services for children including group treatment, psychiatric services, case management, community based programs, Wrap-around programs, volunteer mentoring and individual psychotherapy.	Primary site in Vancouver, 1 office in Hazel Dell, offices in two family resource centers located in East and North Clark County; 3 residential sites and services offered in many schools county-wide, as well as other community sites as needed by consumers	114:2,352	17 Child 1 Hispanic/ Mexican 5 Geriatric 5 DD 3 Southeast Asian/Pacific Islander 2 Deaf			5 Russian 1 German 1 Igbo 2 Chinese 3 French 2 Spanish 1 Laotian 2 Vietnamese 1 Korean 1 Tagalog 1 Cambodian 1 Taiwanese	

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Children's Home Society – is a division of the Children's Home Society of Washington. In Clark County they provide a range of services to children and their families including individual and group treatment, case management, services to foster homes, programs for sexual offenders, out of home care, group treatment, hospital liaison services and psychiatric services.	Primary clinic located in downtown Vancouver with additional offices in Battleground (North County) and East County (Washougal). Additionally, services are provided at other community sites as needed by consumers.	6:111	5 Child			0	
Catholic Community Services provides Crisis Stabilization Services and Intensive Services. Both programs provide home and community based wrap around services with individually tailored care including development of child/family teams, in-home support, respite, family therapy, and psychiatric services.	Offices based in East County with services delivered anytime and anywhere needed (including out of region work to bring extended family members onto the team).	21:42	3 Child	4-5		1 Russian & French 3 Spanish	
Children's Center – provides a full range of mental health services for children and their families. They provide individual therapy, case management, psychiatric services, family therapy, group treatment and school based treatment.	Primary Clinic is located in downtown Vancouver with services in 12 different schools across the county. Staff also provide services in the community and/or in the home, based on consumer choice.	14:369	10 Child 3 DD 2 African American 1 Hispanic 1 Pacific Islander 1 Native American			1 Russian	
Mental Health Northwest (formerly PeaceHealth Behavioral Healthcare)—provides an array of services to adults including individual treatment, case management, group, psychiatric, and psychological services. Their PACT program serves 40 consumers who are high utilizers of services.	Main office is located in downtown Vancouver. Other services are provided wherever and whenever they are needed in the community.	16:305 (4.75:40 PACT)	1 DD 1 Older Adult	10 for PACT 40-50 for other adult outpatient services		0	
Southwest Washington Medical Center – ADAPT Program- provides an outpatient Day Treatment program that serves as a diversion from hospitalization.	Located in downtown Vancouver.	7.11:20	Minority – 4 (2 contract) Deaf Specialist – 1 (contract) Developmentally Disabled – 1				

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Family Solutions-provides a full range of targeted services to children and their families including case-management, family therapy, individual therapy, behavior management skills training, and psychiatric care.	Office is located in downtown Vancouver. Services are also delivered in the home and community, based on consumer need.	3.35:30	2 Child			0	
Institute of Family Development- effective 10-02 this provider no longer contracts with Clark RSN.							
Grays Harbor RSN							
Evergreen Counseling Center (ECC) Provides comprehensive community mental health to the residents of Grays Harbor County. ECC also manages the county-owned Crisis Clinic which provides the crisis telephone line, mobile crisis outreach and crisis interventions, CDMHP ITA evaluations, authorizations for voluntary hospitalizations, plus a ten bed residential center for detox, co-occurring disorders and mental health stabilization.	Hoquiam, Outreach to entire county, particularly the coastal areas.	24.5:2,000* This includes non-TXIX individuals	Geriatric-5 Child -9 Minority-1 DD-2			1	
Behavioral Health Resources (BHR) provides comprehensive community mental health services to adults, older adults and children in Grays Harbor County. BHR is beginning their second year of service in the County. They have just been awarded the contract to manage a transitional housing program for consumers with co-occurring disorders.	Elma, outreach to entire county, particularly East County	5:500* This includes non-TXIX individuals	2 Child Mental Health Specialist				
Greater Columbia BH RSN							
The Rogers Counseling Center**,** a non-profit agency, under a contract with Asotin County, provides crisis response and a full array of outpatient services. The Center is also certified to provide emergency and outpatient evaluation and treatment services.	Clarkston	1:15	Child - 5 Geriatric - 3 Disabilities - 1 Minority - 1	N/A		0	Native American
Benton and Franklin Counties Crisis Response Unit provides crisis and outpatient services to residents in this bi-county area. The Crisis Response Unit is operated by Benton and Franklin County Human Services. The Crisis Response Unit is also certified to provide emergency and outpatient evaluation and treatment services.	Kennewick	1:89* Crisis Svcs only	Child - 4 Geriatric - 2 Disabilities - 1 Minority - 1	N/A		2	Native American
Lourdes Counseling Center, a non-profit agency, under contract with Benton & Franklin Counties, provides outpatient services and is certified to provide outpatient and inpatient evaluation and treatment services. Lourdes Counseling Center	Richland	1:31	Child - 13 Geriatric - 2 Disabilities -1	N/A		4	**African American** Asian/Pacific Islander

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also operates a free-standing inpatient psychiatric facility serving adults and adolescents. The inpatient unit of Lourdes Counseling Center interfaces with mental health providers in GCBH as well as other Regional Support Networks in Washington State in providing inpatient care.			Minority - 1				
La Clinica Migrant Health Care Center, under contract with Benton & Franklin Counties, provides outpatient services through its mental health program, Nueva Esperanza. Nueva Esperanza is also certified to provide outpatient evaluation and treatment services.	Pasco	1:42	Child - 4 Geriatric -0 Disabilities -1 Minority -5	N/A		6	Hispanic African American Asian/Pacific Islander
Lutheran Social Services**,** a non-profit agency, under contract with Benton & Franklin Counties, provides a therapeutic foster care program.	Kennewick	1:3	Child - 5	N/A		0	
Sunderland Family Treatment Services, a non-profit agency, under contract with Benton & Franklin Counties, provides outpatient services and is certified to provide outpatient evaluation and treatment services.	Kennewick	1:28	Child- 7 Geriatric - 1 Disabilities - 0 Minority -0	N/A		0	
Columbia County Services provides crisis response and a full array of outpatient services in this small rural county. The agency is also certified to provide emergency and outpatient evaluation and treatment services.	Dayton	1:7	Child - 2 Geriatric - 2 Disabilities - 2 Minority - 0	N/A		0	
Garfield County Human Services, through a contract with The Rogers Counseling Center, provides crisis response and outpatient services. The agency is also certified to provide emergency and outpatient evaluation and treatment services in this small rural county.	Pomeroy	1:5	Same as Rogers Counseling Center	N/A		0	
Central Washington Comprehensive Mental Health, a non-profit agency, through contracts with Kittitas and Yakima Counties, and GCBH provides crisis response and a full array of outpatient services. The agency is also certified to provide emergency and outpatient evaluation and treatment services. This agency provides mental health services in Yakima, Klickitat, and Kittitas Counties, standardizing care for these three counties (member governments). CWCMH has integrated several services under one roof, coordinates crisis care for three counties, and has achieved unprecedented integration of services.	Yakima Sunnyside Ellensburg CleElum Goldendale White Salmon	1:33	Child -22 Geriatric -9 Disabilities- 5 Minority - 9	N/A		10	Native American Deaf Hispanic African American Developmental Disabilities
Skamania County Counseling Center provides crisis response and outpatient services in Skamania County. The agency is certified to provide emergency and outpatient evaluation and	Stevenson	1:49	Child - 4 Geriatric - 3			0	Developmental Disabilities

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treatment services.			Disabilities - 3 Minority - 0				
Inland Counseling Network, a non-profit agency, under contract with Walla Walla County, provides outpatient services for adults (18-59). This agency provides crisis response services and is certified for emergency and outpatient evaluation and treatment services to all residents in Walla Walla County.	Walla Walla	1:15	Child -1 Geriatric - 0 Disabilities - 0 Minority - 0			0	
Palouse Counseling and Consulting, a limited-liability company, under contract with Walla Walla County, provides outpatient services for children and older adults in Walla Walla County.	Walla Walla	1:10	Child - 2 Geriatric - 1 Disabilities - 0 Minority - 0			4	
Walla Walla County Crisis Response Unit provides crisis services and is certified to provide emergency and outpatient evaluation and treatment services	Walla Walla	New provider 08/02	Child Geriatric - Disabilities - Minority -			0	
Palouse River Counseling Center, formerly Whitman County Counseling Services, provides crisis response and a full array of outpatient services in the most northeastern part of the Region. The agency is also certified to provide emergency and outpatient evaluation and treatment services.	Pullman	1:26	Child - 2 Geriatric -0 Disabilities - 1 Minority - 0			0	
Catholic Family and Child Services, a non-profit agency, under contract with Yakima County, provides outpatient services to children and families in Yakima County. The agency in partnership with the Yakama Nation has a developed an outpatient mental health program for Native American children and families.	Yakima	1:26	Child - 9 Geriatric - 0 Disabilities- 4 Minority- 5			1	Native American African American
Yakima Valley Farmworkers Migrant Health Clinic, under contract with Yakima County, provides outpatient services through its behavioral health unit, Yakima Valley Farmworkers Behavioral Health Services. The behavioral health program also provides crisis response services for children and adolescents in Yakima County.	Yakima	1:35	Child -32 Geriatric -2 Disabilities - 17 Minority -12			5	Asian/pacific Islander Native American Hispanic Developmental Disabilities
King RSN							
NOTE: The King County RSN consumers described below represent approximately 70% of all consumers served in King County.2 The		The figures in the column below describe the	King County RSN understood this requirement to mean	There is no maximum caseload size for King County	Not applicable for King County RSN		

2 Based on the number of outpatient enrollees in the Mental Health Plan in 2002.

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remaining 30% were not enrolled in the outpatient mental health plan, and may have received such services as: crisis, inpatient (without subsequent outpatient), or grant-funded projects.		number of individuals responsible for consumer's treatment plans, and consumers enrolled in the Mental Health Plan (the Medicaid program in King County RSN)	WAC 388-865 definitions for mental health specialists.	RSN. There can be no waitlist for eligible people with Medicaid benefits, so demand and the number of individuals who meet medically necessary criteria influence caseload size.			
ASIAN COUNSELING AND REFERRAL SERVICES	Seattle, Bellevue	21:968 (FTEs) 30:968 (Staff)	Children = 4 Geriatric = 11 Ethnic = 17 (Asian/Pacific Islander) Disability = 1			Cambodian = 4 Mandarin = 5 Cantonese = 11 Japanese = 4 Korean = 4 Lao = 4 Mien = 4 Thai = 1 H'mong = 1 Samoan = 1 Tagalog = 3 Ilocano = 1 French = 4 Taiwanese = 1 Visayan = 1 Vietnamese = 10	Asian and Pacific American Culturally Competent Services
CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER	Seattle	34:380	Children = 24 Disability = 19 Ethnic = 3			ASL = 2	Children; deaf and hard of hearing; disabilities
	Bellevue	15:155	Children = 8 Disability = 8				Children; disabilities
	Federal Way	2:8	Children = 2 Disability = 2				Children; disabilities
COMMUNITY HOUSE MENTAL HEALTH	Seattle	8:300	Ethnic = 3 (African-American = 1; Asian/Pacific Islander = 1; Hispanic = 1) Sexual minority = 1 Developmental Disability = 1 Geriatric = 1			Spanish = 2	
COMMUNITY PSYCHIATRIC CLINIC (CPC)	Seattle/King	50:2500	Child = 7			Spanish = 4	NA

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• Community Psychiatric Clinic-Out Patient	County/Shoreline		Geriatric = 3 Developmental Disabilities = 2 Ethnic Minority = 1			Japanese = 1 Tagalog = 1 French = 1 Chinese = 1 German = 1	
• Community Psychiatric Clinic-Residential3							
Keystone	Seattle	8:64					
El Rey	Seattle	15:60					
Cascade Hall	Seattle	18:60					
• *CPC Subcontractors:*							
Benson Heights (CPC)	Renton	7:53				N/A	
Ryther Child Center (CPC)	Seattle/King County	2:19	Child = 3 Developmental Disability = 1			N/A	
Agape Outreach (CPC)	Seattle/King County	0:5				N/A	
Prime Time (CPC)	Seattle/ King County	3:35				N/A	High need juvenile offenders
CONSEJO COUNSELING & REFERRAL SERVICES	Seattle	18:533	Ethnic = 6 (Hispanic) Geriatric = 1 Children = 3			Spanish = 18	Hispanic community, all ages
Consejo	Federal Way	.5:16				Spanish = .5	Hispanic community
Consejo	Bellevue	1.5:47				Spanish = 1.5	Hispanic community
Consejo	Kent	.5:12				Spanish =.5	Hispanic Community
DOWNTOWN EMERGENCY SERVICE CENTER	Seattle	15:375	Ethnic=1			3 = Spanish	Services to homeless people
EVERGREEN HEALTHCARE	Services provided throughout King County. All services provided out-of-facility/in home. Administrative offices in West Seattle.	6:315	Geriatric = 8			N/A	Older adults & persons who are medically compromised homebound
HARBORVIEW MENTAL HEALTH SERVICES	Seattle	33:718	Ethnic = 7 (Asian/Pacific Islander = 3; African American = 3; Hispanic = 1) Geriatric = 5			Spanish = 2 Ilocano = 1 Tagalog = 2 Other African = 1 French = 2	Geriatric Psychiatry Clinic
HIGHLINE WEST SEATTLE MENTAL HEALTH (HWSMH)	West Seattle & Burien	111:3092	Children = 14 Geriatric = 4 Developmental Disabilities = 2				African Americans; Women/PTSD

3 CPC employs PCPs at their residential facilities.

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			Ethnic = 10 (African/American = 4; Asian = 4; Hispanic = 3) Sexual Minority = 1				
• Highline West Seattle Subcontractors							
Auburn Youth Resources (HWSMH)	Auburn	76: 464	Children = 8			Spanish = 1 French = 1 Cantonese = 1	
Catholic Community Services (HWSMH)	Seattle & Kent	20:150	Children = 5				
Center For Human Services (HWSMH)	North Seattle	16:161	Children = 2 Developmental Disability = 1				
Central Youth & Family Services (HWSMH)	Seattle	25:149	Children = 10 Ethnic = 7 (African American = 5; Hispanic = 1; Native American = 1) Sexual Minority = 1				Specialized case management for homeless African Americans
Children's Home Society (HWSMH)	Auburn	3:27	Children = 3				
Family Services Of King County (HWSMH)	Seattle, Bellevue Renton	28:208	Children = 16 Geriatric = 1 Ethnic = 3 (African American = 2; Hispanic = 1)				
Friends Of Youth (HWSMH)	Issaquah	7:76	Children = 4				
Kent Youth & Family (HWSMH)	Kent	32:406	Children = 8 Ethnic = 1 (African American)				
Lutheran Community Services (HWSMH)	Seattle	18:230	Children = 2 Geriatric = 1 Ethnic = 3 (Native American = 1; Asian = 1; African/American =1) Russian (not a WAC defined specialty)				East African; Eastern European
Northshore Youth & Family (HWSMH)	Bothell, Kenmore, Woodinville	15:103	Children =3 Deaf/Hard of hearing = 1				
Olive Crest (HWSMH)	Kirkland Bellevue	12:11	Children = 9				
Renton Area Youth (HWSMH)	Renton	21:189	Children = 7				

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			Ethnic = 3 (Asian = 2; African American = 1)				
Ruth Dykeman Youth & Family (HWSMH)	Burien	19:178	Children = 14 Developmental Disabilities = 1 Ethnic = 1 (Asian) Sexual Minority = 1				Gay and lesbian youth
Ruth Dykeman Children's Center (HWSMH)	Burien	12:43	Children = 11				
Southeast Youth & Family (HWSMH)	South Seattle	14:106	Children = 2 Ethnic = 2 (African American)				African American grandparents parenting grand children
Southwest Youth & Family (HWSMH)	West Seattle	12:137	Children = 6 Ethnic = 2 (African American) Developmental Disability = 1				
Vashon Youth & Family (HWSMH)	Vashon	15:74	Children = 3				
Youth Eastside Services (HWSMH)	Bellevue, Redmond,Kirkland, Sammamish	42:339	Children = 8 Ethnic = 4 (African American = 1; Hispanic = 2; Asian = 1)				Gay/lesbian youth
PUGET SOUND EDUCATIONAL SERVICES DISTRICT	All services provided in the home community of the child and family. All children reside in King County	1:14	Children = 2				High need, multi-system children (MH, special education, child welfare)
SEA MAR COMMUNITY HEALTH CENTER	Seattle	4:125	Ethnic = 2 (Hispanic) Geriatric = 1 Child = 1			Spanish = 4	Hispanic community, all ages
SEATTLE CHILDREN'S HOME	Seattle Auburn	12:183	Child = 19 **Ethnic = 4** Sexual Minority = 1 Chemical Dependency = 1 Developmental Disabilities = 4			Spanish = 2 Vietnamese = 1 Greek = 1 ASL = 1	Children Developmental Disability
SEATTLE COUNSELING SERVICES FOR SEXUAL MINORITIES	Seattle	15:244	Children = 1 Sexual Minority = 8 Ethnic = 1(Native			N/A	Gay/lesbian/bi-sexual/transgendered / & questioning

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			American)				people
SEATTLE MENTAL HEALTH	Seattle	118:2078	Ethnic = 4 (African American = 2; Hispanic = 1; Native American = 1) Chemical dependency = 4 Child = 22 Developmental disabilities = 10 Deaf = 5 Geriatric = 5			Spanish = 12 (and for CHS add: 1) French = 3 German = 2 Russian = 1 Hebrew = 1 Gaelic = 1 Hindi = 1 ASL = 10 Japanese = 2 Mandarin = 2 Tagalog = 1 Taiwanese = 1 (all sites)	Children DD/MH Deaf Geriatric Co-Occurring (MH & D/A)
(Seattle Mental Health)	Bellevue/Redmond	44:1280	Chemical Dependency = 1 Child = 13 Developmental disability = 3 Geriatric = 2				Children DD/MH Geriatric
(Seattle Mental Health)	Renton	37:807	Chemical dependency = 2 Children = 8				Children DD/MH Co-Occurring
(Seattle Mental Health)	Auburn/Kent	32:1254	Ethnic = 3 (African American = 1; Hispanic = 2) Children = 6 Developmental Disabilities = 3 Geriatric = 2				Children Deaf DD/MH Geriatric

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• Seattle Mental Health Subcontractors							
Children's Home Society (SMH)	Seattle	1:10	Children = 1				Children
Harborview Trauma (SMH)	Seattle	2:100	Children = 1				Children
Pioneer HS Counseling (SMH)	Seattle	1:28	Children = 1				Children
Ryther Child Center (SMH)	Seattle	2:50	Children = 3 Developmental disabilities = 1				Children DD/MH
THERAPEUTIC HEALTH SERVICES	Seattle	16:482	Ethnic Minority = 9			Amharic = 1 Swahili = 1 Japanese = 1 French = 1 Luthyia = 1 Cambodian = 1	African-American Community
• Therapeutic Health Services Subcontracts							
Atlantic Street Center (THS)			Children = 11				
VALLEY CITIES COUNSELING & CONSULTATION	Kent, Renton, Auburn, Federal Way, Covington, Maple Valley, Enumclaw	59:1799 VCCC employees 59 PCPs (not FTEs)	Chemical Dependency = 9 Child = 17 Geriatric = 2 Ethnic Minority = 3 Developmental Disabilities = 2			Spanish = 2 Russian = 1 Czech. = 1 French = 1 German = 1 Punjabi = 1	Developmentally disabled Older Adults Children African- American Russian/American Hispanic-/Americans Czechoslovakian/A merican German/ American
YMCA MENTAL HEALTH SERVICES	Seattle	15:150	Ethnic = 2 Child = 8				Wrap around services for extremely high needs youth
North Central RSN		77:2627	20 Child 8 Geriatric 5 Minority 5 Disability (2 of which are hearing impaired specialists)	6,431 hours/ month*			
Grant Mental Healthcare	Moses Lake 40.75 Quincy 6.5 Grand Coulee 3 Mattawa .25	50.5:2100	13 Child 6 Geriatric 3 Minority 2 Disability	N/A	31	13 Clinical 6 Admin	Hispanic Children's Case Management Program
Community Counseling Services of Adams County	Othello 4.25 Ritzville .7	5:370	3 Child 2 Geriatric 1 Minority	N/A	0	2 Admin	

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			1 Disability				
Okanogan Community Counseling Services	Omak 27.9 Brewster 1.8 Tonasket 1.0 Twisp 1.9 Oroville 2.4	35:1,393	3 Geriatric 4 Child 1 Minority	N/A	35	4 Clinical 2 Admin	
Northeast WA RSN							
Ferry County		125:9	1 Child Specialist 1 Ethnic Minority Specialist				
Pend Oreille		135:10	2 Ethnic Minority Specialist 4 Child Specialist				
Lincoln County		101:10	3 Child Specialist 1 Geriatric Specialist				
Stevens County		328:21	5 Child Specialist 2 Geriatric Specialist				
North Sound RSN							
Catholic Community Services provides crisis residential, CLIP, counseling and case management services for children and families in Skagit and Whatcom Counties.	Bellingham-#20 Mt. Vernon-#12	1: 30.8	Child:15	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be measured with new contract.	0	

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Compass Health provides crisis, residential, outpatient counseling, and case management services to children, adults, and older adults in Snohomish County. It operates from over 40 different locations. It coordinates the Asian/Pacific Islander Mental Health Program for the NSRSN. It provides specialized services for homeless, mentally ill in jail, developmentally disabled, head injured, etc.	Arlington #19.6 Edmonds/ Lynnwood #23.8 Everett #62.5 Monroe/Snohomish #11.8 Marysville #4	1:40	Geriatric: 6 Child: 45 Minority: 2 Disabled:6	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be this measure-ment with new contract.	18	
Community Mental Health Services provides crisis, residential, outpatient counseling, and case management to children, adults, and older adults in Island, San Juan, and Skagit Counties. It operates over ten sites in these three counties. It provides specialized services for Native Americans and Asian/Pacific Islanders, as well as outreach/liaison to the homeless shelter. A jail service program is funded and being developed. In Island County, the crisis respite program is jointly funded by mental health, DCFS, and DASA.	Camino Isld. # 1.8 Coupeville #12 Langley # 3 Mt. Vernon #38.25 Oak Harbor # 2 Lopez Island # 1 Friday Harbor #4 Orcas Island #1.5	1:38	Geriatric: 7 Child: 14 Minority: 4 Disabled: 1	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be this measure-ment with new contract.	2	
Whatcom Counseling and Psychiatric provides crisis, residential, outpatient counseling, and case management services in Whatcom County. It operates sites. It provides specialized services for Asian/Pacific Islanders and mentally ill in jail.	Bellingham # 29	1:40.8	Geriatric: 7 Child: 7 Minority: 2	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be this measure-ment with new contract.	1	
Seamar provides outpatient counseling and case management services to children, adults, and older adults in Skagit, Snohomish, and Whatcom Counties. It specializes in serving Hispanic people. All of their counselors are bi-lingual. It operates from three different sites and provides services to the homeless.	Bellingham #3 Everett #5 Mt. Vernon #2	1:30 1:30 1:30	Geriatric: 1 Child: 5 Minority: 7	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be this measure-ment with new contract.	8 certified interpreters	
Lake Whatcom Residential Services provides residential and case management services to adults and older adults in Whatcom County. It operates a 65 bed residential facility and a number of apartments.	Bellingham # 9	1:23.7	Unknown	Caseload will be expanded depending on residential capacity.	Not measured at this time. Will be this measure-ment with new contract.	Unknown	
Rainbow Resources provides residential and case management services to adults and older adults in Snohomish County. It operates two residential facilities and supervises consumers living in community apartments.	Everett #11	1:31.7	Unknown	Caseload size will be adjusted depending on demand or new staff will be hired.	Not measured at this time. Will be this measure-ment with new contract.	Unknown	
Peninsula RSN							
Kitsap Mental Health Services	69 Bremerton 4 Port Orchard	Averages 1:31	Geriatric-5 Children-26	Varies from 1:16 for ACT model	Capacity is expanded as	5	MICA: 1 Sexual Minority

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
Provides comprehensive community mental health services within Kitsap County, including crisis services, outpatient services, residential programs, day treatment, as well as inpatient Evaluation and Treatment services.	1 Poulsbo		Minority-3 Disabled- 2	clinicians to 1:85 for individuals in need of brief treatment	necessary to meet the needs of the population served		PRSN contracted Hearing Impaired: 1 African American :1 Asian/ API: 1 Hispanic : 2
Peninsula Community Mental Health Center - Provides comprehensive community mental health services within East Clallam County, including crisis services, outpatient services, residential programs, day treatment.	52 in Port Angeles/Sequim	1:30	Geriatric-3 Children-8 Minority-1 Disabled-3	Varies based on severity and functioning level, and current demand	Direct service staff are at caseload capacity 90% of the time	0	MICA:3 DD:3 Veteran/PTSD:3 PRSN contracted Hearing Impaired: 1 African American :1 Asian/ API: 1 Hispanic : 2
Jefferson Mental Health Services - Provides comprehensive community mental health services within East Jefferson County, including crisis services, outpatient services, residential programs, day treatment	12 in Port Townsend	1:26	Geriatric-1 Children-6	1:40	100%	0	PRSN contracted • Hearing Impaired: 1 • African American :1 • Asian/ API: 1 • Hispanic : 2
West End Outreach Services - Provides comprehensive community mental health services within Western Clallam and Jefferson Counties, including crisis services, outpatient services, residential programs, day treatment	7.95 Forks .2 Clallam Bay .6 Neah Bay .3 La Push	1:30	Geriatric-2 Children-5 Minority-2 Disabled-1		All over Capacity	2	MICA DD Native American Sexual Minority: Gay, Lesbian, Bisexual, Transgendered PRSN contracted • Hearing Impaired: 1 • African American :1 • Asian/ API: 1 • Hispanic : 2
RMH Services Provides community mental health services within Kitsap County, as an alternative service provider. The services are contracted for specific individuals that meet PRSN criteria for ADA accommodations. These services may include a variety of outpatient services, such as medication evaluation and management, group treatment, and case management services.	1- Bremerton	1:2	none	Varies	none	0	PRSN contracted consultants: • Hearing Impaired: 1 • African American :1 • Asian/ API: 1

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
							• Hispanic : 2
Pierce County RSN							
nsive Mental Health	oma) and West Pierce County	1:22	Geriatric 7 Children 26 10 1	28 Children 5-30 Adults *ildren at Chance (inpatient)*	All	13 languages plus ASL	
kes Mental Health Foundation	South Pierce County	1:37	Geriatric 3 Children 16 10 1	22 Children 35 Adults	All	2 languages plus ASL	
aritan Behavioral Healthcare	East Pierce County	1:23	Geriatric 14 Children 38 Minority 6 Disabled 3	30 Children 30 Adults	All	6 languages	*Community support services for Asian/Pacific Islanders*
ommunity Services	Countywide	1:10	Geriatric 1 Children 18 9 3	6 *home based services for children and their families*	All	10 languages	
ribal Health Authority	Countywide	1:87	Geriatric 1 Children 5 7	-60 Children 60+ Adults re current case load sizes, however, caseloads are not set by number of individuals but rather clinical hours per week)	All		*Community support services and domestic violence intervention services for Native American /Alaskan Native children and families*
ommunity Health Centers	Countywide	1:48	3	30 Kids 35 Adults *e load sizes are based on full-time positions, however, actual FTEs vary from 0.4 to 1.0)*	All	5	*Community support services for primarily Spanish speaking individuals*

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
Southwest RSN							
Lower Columbia River Mental Health Center - Established more than 40 years ago. Full array of outpatient mental health services for children, adults, and elderly.	Longview/Kelso (direct service staff have cell phones and provide outreach services)	Current: 1:29	11 child, 2 geriatric MH specialists and 1 addictionologist on staff. Contracts with African-American, Native American, Hispanic, DD, Hard of hearing/deaf, Asian specialists	Currently estimated to be 1350	N/A	4	None
CBS, Launched in 1998, this consortium has St. John Medical Center as lead. S.L. Start and Toutle River Ranch dba Community Connections are partners. Strong emphasis on solution focus. Full array of outpatient mental health for all ages.	Longview/Kelso (direct service staff have cell phones and provide outreach services)	Current: 1:24	3 (4 in one month) child and 1 geriatric MH specialists on staff. Contracts with African-American, Native American, Hispanic, DD, Hard of hearing/deaf, and Asian specialists.	Currently estimated to be 1100	N/A	One	One has expertise with sex offenders
Spokane County RSN							
Catholic Family Services: Provides Individual and Group therapies. Subcontracts to RSN.	Downtown Spokane = 1 Spokane Valley = 1 South Spokane = 1 North Spokane = 2	5/840	3 Child Mental Health Specialists 5 Mental Health Specialists, 1 Geriatric Specialist	40	0	0	0
Children's Home Society: Provides Individual and Group therapies. Subcontracts to RSN.	Spokane Valley = 1 Spokane Northeast = 1 Spokane West Central = 0.5 Spokane East Central = 1.0 Miscellaneous Sites (TLC, New Horizons, In-home) = .50	4/500	3 Child Mental Health Specialists	40	All	0	0
Family Service Spokane: Provides Individual and Group therapies. Subcontracts to RSN	Downtown Spokane (main office) = 12 Downtown Spokane (Neighborhood Support Project) = 4.0 Spokane Valley = 4.0	20/1275	16 Mental Health Specialists 6 Child Mental Health Specialists 3 Disabled Mental Health Specialists 1 Geriatric Specialist	35	All	0	Developmental Disability; Geriatric
Lutheran Social Services: Specializes in services to sexual abuse survivors. Subcontracted to RSN for Individual and Group therapies	Deer Park = .8 Spokane Valley = 1.4 Downtown Spokane = 18.11	20.91/1353	13 Child Mental Health Specialists	36	18	4 (French, Spanish, American Sign Language)	Trauma Victims, some of which have developmental

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
	Cheney= .6						disability or are sexual minorities
Sacred Heart Program: A partial hospitalization program located at an inpatient facility, serving children. Subcontracted to RSN. Not a primary care provider.	Spokane = 0 (non PCP model)	N/A	1 Child Mental Health Specialist	Up to 13 children enrolled daily	N/A	0	
Spokane Mental Health: Provides a wide array of services, including Crisis Response, Case Management, Medical Management/ Psychiatry, Vocational Prep/ Rehab, MICA services, Ethnic Consultation, and others. Serves all age cohorts	Downtown Spokane: 90 Northeast: 23 Northwest: 2 East Central: 9 Valley: 5 Outlying Schools and Communities: 5	134/6829 134/3332 for urgent care	37 Child Mental Health Specialists 17 Geriatric Mental Health Specialists 9 Minority Mental Health Specialists 7 Disability Mental Health Specialists	99 for Medication Management 62 for Elder Outpatient 56 for Adult Case Mgmt. 51 for Child Outpatient 36 for Adult Outpatient 32 for Multicultural	N/A	3 German 1 Latin 4 Spanish 1 French 2 Sign Language	Ethnic Minorities; Geriatric
The RSN no longer contracts with St. Luke's.							
Grief Counseling: Specializes in grief counseling services.	Spokane County: .375	1/7	.375 Grief Specialist	10		One	Bi-lingual and minority (Hispanic)
HOPE: Provide adult OP treatment for mental illness and chemical addictions (Co-occuring disorders)	Downtown Spokane: 5	5/119	0	20	0	1 Spanish	Co-Occuring work
NATIVE Project: Provides case management to adolescents (10-18) who have co-existing disorders, provides individual, group and family counseling	West Central: 1	1/17	1 adolescent MICA specialist	18	All	1	Ethnic minorities are priority population

Attachment B.III.a. - REGIONAL SUPPORT NETWORK Contracted Providers (2003)	*Geographic distribution of PCPs*	*Ratio of PCPs to consumers*	*Type and number of specialist*	*Maximum case-load size (if appropriate)*	*Number reached case-load capacity*	*Number with bilingual capabilities*	*Other culturally defined specialty service*
Thurston-Mason RSN			18 child 19 geriatric 4 Native American 2 Asian Pacific 1 African American 3 Hispanic 6 disability			1 Amer. Sign 2 Cantonese 3 German 1 Mandarin 1 Russian 5 French 11 Spanish 1 Vietnam. 3 other	Geriatric home bound services. Native American Services Homeless Outreach
Behavioral Health Resources Provide outpatient ,residential and co-disordered services to all age groups in Thurston and Mason counties.	Olympia, Lacey Yelm, Shelton, Rochester, Belfair	37:1200	Co-disordered Services	Thurston County and Mason County	37:1200		
South Sound Mental Health Services Provide outpatient to all age groups in Thurston county and Crisis services to Thurston and Mason counties.	Olympia/Tumwater	15:430	DD Crisis Outreach Path Outreach 6 CDMHPs	Thurston County	15:430		
Providence St. Peters Hospital Provide outpatient services to older adults in Thurston and Mason. Provide crisis services in the ER.	Thurston and Mason Counties	2:40	Older Adult Specialty Program				
Timberlands RSN							
Cascade MH Care	Chehalis/Centralia: 47 Morton (East County): 1	48:1,619	Child = 4 Geri = 1			Bengali: 1 French: 1 Gha: 1 Russian: 1 Spanish: 2	
Willapa Counseling Center	Long Beach: 20 South Bend: 3	23:665	Child = 4 Geri = 2 EM = 1 DD = 1			Spanish: 1	
Wahkiakum County MHS	Cathlamet: 6	6:133	Child = 2 Geri = 1				

End of Attachment B.III.a.

b._**x**_[Required if elements III.a.1 ~~and III.a.2~~ were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits ~~and open panels were~~ adequate. Please describe the results of this monitoring.

The state has mandatory enrollment and all Medicaid enrollees are in the PIHP for mental health.

Upcoming Waiver Period -- Please describe the capacity standards for the upcoming two year period.

a. MCO/PIHP/PAHP Capacity Standards

1.___ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2.___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

3._**x**_ [Required] The State ensures that the number of ~~providers~~ *community mental health agencies* under the waiver is adequate to assure access to all services covered under the contract. Please describe how the State will ensure that ~~provider~~ *community mental health agency* capacity will be adequate.

By contract, the PIHPs must ensure the adequate capacity to serve the entire Medicaid population in their service area that have a medically necessary need for mental health services in the public mental health system. The PIHPs are responsible for the resource and utilization management of the system. The PIHPs are required in contract to submit changes that result in reduced capacity to the MHD prior to the change. There has been a net increase in new agencies over this modification period. The provider ratio is shown in Attachment B.III.a.3.

Attachment B.III.a.3.

Attachment B.III.a.3.	*Recipient-To Provider Agency Ratio (2003)*	*Expected Change For The Renewal Period (03-05)*
Chelan-Douglas RSN		
Chelan-Douglas Behavioral Health Clinic	2,045:1	2249:1
Children's Home Society	348:1	383:1
Catholic Family & Child Service	411:1	452:1
Clark County RSN (CY 2002)		**7,991:7.75**
Columbia River Mental Health	5,189:1	Includes crisis recipients
Children's Home Society	171:1	
Children's Center	1,375:1	
PeaceHealth Behavior Healthcare	727:1	01/01/2002-11/31/2002
Mental Health Northwest	246:1	12/01/2002-12/31/2002
Institute of Family Development	26:1	01/01/2002-09/30/2002
Catholic Community Services	103:1	
Family Solutions	32:1	
Southwest Medical	122:1	
Grays Harbor RSN		
Behavioral Health Counseling	150:1	
Evergreen Counseling	2,175:1	
Greater Columbia BH RSN		**GCBH expects 5-10% increase in consumer population based on information from previous reporting periods.**
The Rogers Counseling Center	682:1	
Garfield County Services	80:1	
Columbia County Services	141:1	
CWCMH – Klickitat	465:1	
Skamania County Counseling Services	222:1	
Inland Counseling Network	910:1	
Whitman County Mental Health (Name change to Palouse River Counseling Center 02/03)	517:1	
CWCMH – Yakima	5,049:1	
CWCMH – Kittitas	790:1	
Sunderland Family Treatment	1,463:1	
Lourdes Counseling Center	1,546:1	
Yakima Valley Farm Workers	1,206:1	
Catholic Family & Child Services	906:1	
Nueva Esperanza	588:1	
Lutheran Social Services	26:1	
Southeast Children's Home Society	287:1	(Contract ended in July 2002)
Benton & Franklin County Crisis Response Unit	1,364:1	

Attachment B.III.a.3.	*Recipient-To Provider Agency Ratio (2003)*	*Expected Change For The Renewal Period (03-05)*
St. Mary Medical Center	163:1	Contract ended June 2001
Palouse Consulting and Counseling	Replaced St. Mary MC- Contract began in July 2001. Replaced SECHS – contact began August 2002	
Walla Walla County Crisis Response Unit	Crisis Services separated from OP services – new provider August 2002	
King County RSN*		
Asian Counseling and Referral Service *Atlantic Street Center – sub* *Auburn Youth Resources – sub* *Center for Human Services – sub* *Children's Home Society – sub*	1097:1	
Children's Hospital & Medical Center	581:1	
Community House Residential: Spring Manor	391:1	
Community Psychiatric Clinic	3,677:1	
Consejo Counseling	857:1	
Downtown Emergency Service	1084:1	
Evergreen Community Health Care	689:1	
Harborview Mental Health Center CTU-HMCER	1,732:1 5,315:1	
Highline-West Seattle Mental Health *Catholic Community Services- sub* *Kent Youth and Family – sub* *Lutheran Social Services – sub* *Northshore Youth and Family- sub* *Family Services of King County – sub* *Federal Way Youth & Family – sub* *Friends of Youth – sub* *Renton Area Youth & Family – sub* *Ruth Dykeman Child Center – sub* *Ryther Child Center – sub*	6,477:1	
Seattle Children's Home	715:1	
Seattle Counseling *Seattle Indian Health Board – sub*	290:1	
Seattle Mental Health *Southeast Youth and Family – sub* *Southwest Youth and Family – sub*	8290:1	
Therapeutic Health Services	645:1	

* This is total served at each agency and includes those who are served at a subcontract agency of that organization. Total served does not include those who may be new "drop-in" or crisis services only, except at Harborview CTU. Counts at each agency and Total are unduplicated.

Attachment B.III.a.3.	*Recipient-To Provider Agency Ratio (2003)*	*Expected Change For The Renewal Period (03-05)*
Valley Cities Counseling *Vashon Youth and Family – sub*	2992:1	
YMCA *Youth Eastside Services – sub*	153:1	
Puget Sound ESD	41:1	
SeaMar	107:1	
Muckleshoot Indian Tribe	28 children and 12 families per quarter.	
Merino Interpreting *Renton Area Youth & Family – sub* *Ruth Dykeman Child Center – sub* *Ryther Child Center – sub*		
Valley Cities Counseling *Vashon Youth and Family – sub*	940:1	
YMCA *Youth Eastside Services – sub*	93:1	
Puget Sound ESD	12:1	
North Central WA RSN		
Grant Mental Healthcare	2,100:1	4,600:1
Comm. Counseling Services of Adams County	370:1	800:1
Okanogan Community Counseling Services	1,393:1	3,320:1
Northeast WA RSN		
Stevens County	328:1	
Ferry County	125:1	
Lincoln County	101:1	
Pend Orielle County	135:1	
North Sound RSN	18,984	NSRSN expects increases due to population growth and increases in Medicaid eligible.
Catholic Community Services	945:1	
Compass Health	8487:1	
Community Mental Health Services	3343:1	
Whatcom Counseling and Psychiatric	2711:1	
Seamar	550:1	
Lake Whatcom Residential Services	369:1	
Rainbow Resources	98:1	
Skagit E & T	262:1	
Snohomish County Human Services (CDMHP)	1862:1	
Snohomish County E & T	357:1	
SUN Community	25:1	
Peninsula RSN		
Kitsap Mental Health Center	4102:1	
Peninsula Community Mental Health Center	1,740:1	

Attachment B.III.a.3.	*Recipient-To Provider Agency Ratio (2003)*	*Expected Change For The Renewal Period (03-05)*
Jefferson Mental Health Services	543:1	
West End Outreach	243:1	
RMH Services	2:1	
Pierce County RSN		
Comprehensive Mental Health	3,668:1	Pierce County RSN anticipates a decrease in recipient-to-provider agency ratios due to a reduction in state Medicaid rates and revised eligibility criteria.
Greater Lakes Mental Healthcare	4,205:1	
Good Samaritan Behavioral Healthcare	3,521:1	
Catholic Community Services	520:1	
Puyallup Tribal Health Authority	695:1	
Sea Mar Community Health Center	199:1	
Southwest RSN	1,700:2	2,400:2
Lower Columbia	850:1	1,200:1
Center for Behavioral Solutions	850:1	1,200:1
Spokane County RSN		
Catholic Family Services	840:1	
Children's Home Society	500:1	
Spokane Mental Health	6,829:1	
Family Services Spokane	1,275:1	
Lutheran Social Services	1,353:1	
Sacred Heart Acute Divers.	132:1	
Native Project	13:1	
Hope Partnership	119:1	
Larry Cronin	7:1	
Thurston-Mason RSN		Numbers are projected to remain the same for the biennium.
Behavioral Health Resources	3,245:1	
South Sound Mental Health	1,300:1	
St. Peters Hospital	223:1	
Timberlands RSN Twelve month unduplicated count of enrolled consumers served, ending in January '03. Does not include crisis services		At this time, no changes are anticipated.
Cascade MH Care	1,619:1	
Willapa Counseling Center	665:1	
Wahkiakum County MH Services	133:1	

End of Attachment B.III.a.3.

b. PCP Capacity Standards

1.___ The State has set capacity standards for PCPs within the MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):

(a)___ PCP to enrollee ratio

(b)___ Maximum PCP capacity

(c)___ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans.

2._**x**_ The State ensures adequate geographic distribution of ~~*PCPs*~~ *CMHA* within MCO/PIHPs/PAHPs. Please explain:

The MHD requires written assurance from the PIHPs of a sufficient number, mix, and geographic distribution of CMHAto meet an appropriate range of medically necessary mental health services. The PIHP must also ensure they can meet the medically necessary needs of the anticipated number of enrollees. The PIHP must meet access and travel standards. Additionally, the PIHPs must also assure they can adjust the capacity to meet the needs of enrollees as they shift within the service area. Changes in the number, mix, and/or geographic distribution of providers must be submitted to the MHD. The state monitors this through grievance and by on-site reviews. The PIHP must also have enough MHCP to meet the need of the population in the service area.
Please see Attachment B.III.a.

3.___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

c. Specialist Capacity Standards

1.___ The State has set capacity standards for specialty services. Please explain.

Not applicable the entire waiver is a specialty service and the PIHP may only contract with Community Mental Health Agencies licensed to provide community mental health. Services must be provided by or under the supervision of a mental health professional. WAC has additional requirements for mental health services for Children, Ethnic Minority, Geriatric and Disability Mental Health Specialists as described in 388-865-0150 and 388-865-405(5). By contract, the PIHP must comply with WAC and have the capacity and staff to meet the needs of the population.

2.___ The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

Specialist Provider Type	Adult	Pediatric	Standards
Addictionologist and/or Certified Addiction Counselors			
Allergist/Immunologist			
Cardiologist			
Chiropractors			
Dentist			
Dermatologist			
Emergency Medicine specialist			

Specialist Provider Type	Adult	Pediatric	Standards
Endocrinologist			
Gastroenterologist			
Hematologist			
Infectious/Parasitic Disease Specialist			
Neurologist			
Obstetrician/Gynecologist			
Oncologist			
Ophthalmologist			
Orthopedic Specialist			
Otolaryngologist			
Pediatrician			
Psychiatrist			
Pulmonologist			
Radiologist			
Surgeon (General)			
Surgeon (Specialty)			
Other mental health providers (please specify)			
Other dental providers(please specify)			
Other (please specify)			

IV. Capacity Monitoring

Previous Waiver Period

a. **_x_** [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PIHP/PAHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint; item B.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

The MHD on-site team monitors for delays in accessing services when they are in the CMHA network. The administrative team assures the PIHPs are utilizing their level of care process and through utilization review monitoring adjusting capacity appropriate to the need of the population. The MHD also monitored RSN capacity through complaints and grievances related to access. The reports have been sent to CMS. The second year of monitoring is not complete as of this modification and results will be included in our renewal application.

Upcoming Waiver Period -- Please indicate which of the following activities the State employs:

a. **_x_** Periodic comparison of the number and types of Medicaid ~~providers~~ *CMHAs* before and after the waiver.

b. ___ Measurement of referral rates to specialists.

c. ___ Provider-to-enrollee ratios

d._x_ Periodic MCO/PIHP/PAHP reports on ~~provider~~ *CMHA* network

e.___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f._x_ Tracking of ~~complaints/~~grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k._x_ Consumer ~~Experience~~ *MHSIP satisfaction* Survey, including persons with special needs,

l._x_ Other (Please explain): *MHCP*-to-enrollee ratios

V. Coordination and Continuity of Care Standards

Upcoming Waiver Period - Check any of the following that the State requires of the MCO/PIHP/PAHP:

a.___ Primary Care and Coordination

1._NA__ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees. Per the CMS definition this waiver does not meet the definition of Primary Care see 5 below

2._NA__ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services. Per the CMS definition this waiver does not meet the definition of Primary Care see 5 below

3._NA__ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP. Per the CMS definition this waiver does not meet the definition of Primary Care see 5 below

4._x__ [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. The PIHP is required to meet all privacy and confidentiality requirements when participating in coordinated care with the client's permission.

5._**x**_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the primary care requirements of 42 CFR 438.208. Please explain.

As a mental health carve out, our system does not meet the definition of Primary Care Provider. The PIHPs are required to provide continuity of care between inpatient and outpatient mental

health services and are also required to refer Medicaid consumers to their physical health care provider when they note they are in need of a physical. The PIHPs are also required to work in partnership with other Medicaid managed care programs within the state when appropriate and asked.

b.___ Additional services for enrollees with special health care needs.

1._**x**__ [Required] Identification. The state has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

Per CMS decision, all persons covered meet the definition.

2._**x**__ [Required] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the state to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

–All clients receive an intake assessment.

3._**x**__ [Required] Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

(a)_**x**_ Developed by enrollees' ~~primary care provider~~ MHCP with enrollee participation, and in consultation with any specialists care for the enrollee

(b)___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

(c)_**x**_ In accord with any applicable WAC ~~State quality assurance and utilization review standards~~.

4._**x**__ [Required] Direct access to specialists. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

This is a mental health carve-out waiver, therefore, all services are specialty services.

5._ _ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208.

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a._x__[Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint; item B.VI. Upcoming Waiver Period, 1999 Renewal Waiver Preprint.].

This section of the pre print has been changed significantly. In the 01-03 waiver renewal, Continuity and Coordination of Care Standards marked were: Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs; mental health education/promotion; each provider maintains, for Medicaid enrollees, health record that meet the requirements established by the MCO/PHP, taking into account professional standards; Appropriate and confidential exchange of information among providers; informs enrollees of specific health conditions that require follow-up and, if appropriated, provides training in self-care; deals with factors that hinder enrollee compliance with prescribed treatments or regimes; case management (please define your case management programs.

These items have been monitored in the past. As this modification is in the middle of our two-year renewal cycle, the renewal will contain monitoring information. The preprint changes in this modification are those that we will be following and based on the changes in the regulation and the guidance of CMS there are sections (e.g., primary care and marketing) that are being changed.

b._**x**_[Required for all elements checked in the previous waiver submittal if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PIHP/PAHP providers were educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems were identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP/PAHP providers. Please describe how this issue was addressed in the PIHP/PAHP program.

The RSNs work with both Healthy Options providers and other physicians around children, adults, and older adults with regards to mental illness, pharmacy and cross-system care. These sub-contractors work closely together and do cross-system trainings on access/referral to services, symptoms, reactions, and integrated planning.

c._**x**_[Required if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees were monitored in this waiver program.

Pharmacy services are provided by MAA through a fee-for-service system. The MHD does monitor if any grievances were filed with our system regarding pharmacy and notifies MAA of those grievances. QA & I staff as part of the case record review look at medication prescription to see that the medications are prescribed by a qualified physician or an ARNP with prescriptive authority and that they are reviewed/monitored on at least a three month cycle. Monitoring would/could include side effects, lab tests, etc.
They also review storage as part of the ADA/fed requirement walk around. WAC 388-865-0458.

Upcoming Waiver Period -- Please describe how standards for continuity and coordination of care will

be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination and continuity standards checked above in Item B.V?

b. Specify below which providers are excluded from the capitated waiver and how the State explicitly requires the MCO/PIHP/PAHP to coordinate health care services with them:

1.____ Mental Health Providers (please describe how the State ensures coordination exists):

2._**x**_ Substance Abuse Providers (please describe how the State ensures coordination exists): see below for all services

3._**x**_ Local Health Departments (please describe how the State ensures coordination exists):

4._**x**_ Dental Providers (please describe how the State ensures coordination exists):

5._**x**_ Transportation Providers (please describe how the State ensures coordination exists):

6._**x**_ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7._**x**_ Developmental Disabilities (please describe how the State ensures coordination exists):

8._**x**_ Title V Providers (please describe how the State ensures coordination exists):

9._**x**_ Women, Infants and Children (WIC) program

10._**x**_ Indian Health Services providers

11.___ FQHCs and RHCs not included in the program's networks

12.___ Other (please describe):

The RSNs have working partnerships with a variety of other community services. Their role in County Government is one of the reasons for sole source contracting. They have the responsibility for many shared consumers. The RSNs and CMHAs are required to participate in multi-system coordination efforts whenever possible. They are required to refer consumers to alternate or additional services that the CMHA or the consumer's individual Mental Health Care Provider believes the consumer needs to complete or aid in the recovery process. However, they must use caution and care not to violate confidentiality of mental health care and the consumer's right to privacy. The RSNs have developed and will be implementing service protocols with regards to children and older adults. The annual reports submitted to CMS describe and provide examples of continuity and coordination of care.

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCOs, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint, item C.1 Upcoming Waiver Period, 1999 Waver Renewal Preprint].

The Quality Strategy Plan is still under review by CMS and may require some modifications

Attachment C.I.a.

Washington State Mental Health Quality Strategy

I. Introduction and Purpose

The Quality Strategy is meant to be a coordinated, systematic approach to the planning, implementation and management of our quality assessment and improvement strategy. This strategy is expected to continuously and consistently monitor the appropriateness and quality of the consumer care delivery system in Prepaid Inpatient Health Plans (PIHPs) providing mental health care to eligible consumers in Washington State.

II. Goal

Our goal is to assess, monitor and measure for improvement the mental health services provided to members served by PIHPs contracting with the Mental Health Division (MHD). This goal requires the development of a process through which the MHD and the PIHPs (also known as Regional Support Networks or RSNs) work in a collaborative manner to establish objectives and timetables for improvement of health care service and delivery if and when needed. The quality strategy also seeks to improve Medicaid Managed Care's ability to meet the priorities of the MHD, Medicaid program, and Medicaid managed care programs in Washington State.

III. Mission Statements

The mission of the Washington State mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work, and participate in their communities. The mission of the Mental Health Division is to administer a public mental health system

that promotes recovery and safety.

IV. Objectives

A. At a minimum, the PIHPs will be in compliance with and seek to continuously improve outcomes compliant with Federal and State statutes and requirements. This includes, but is not limited to, State contract and program requirements such as those listed below:

1. Availability of services
2. Continuity and coordination of care
3. Access standards
4. Enrollee information
5. Enrollee rights and protections
6. Confidentiality and accuracy of enrollee information
7. Provider selection
8. Sub-contractual relationships and delegation
9. Practice guidelines applicable to mental health
10. Health Information Systems
11. Mechanisms to detect both under- and over-utilization
12. Quality improvement
13. Utilization management
14. Member services
15. Provider services
16. Record keeping
17. Data reporting.

B. The PIHP's quality management process must include ongoing quality improvement efforts that are implemented and maintained through internal processes that meet the following content requirements:

1. RSN/PIHP contract provisions that require the PIHPs to assess the quality and appropriateness of care and services furnished to all Medicaid enrollees and to individuals with mental illness. All Medicaid persons requesting mental health services shall be screened, assessed and authorized based on Access to Care standards and minimum eligibility requirements. Benefits for Medicaid special health care needs populations as defined by CMS include persons who meet the non-Medicaid "state priority populations". They include:
    a. SSI beneficiaries of all ages,
    b. adults 65 years of age and older,
    c. five groups of children: foster children, children in adoption support, blind children, disabled children, and children on Title V
    d. Children with multiple needs who meet EPSDT requirements shall receive services that comply with the EPSDT plan found in the MHD contract.
2. The PIHP shall conduct monitoring and review its ongoing quality management process to ensure continued assessment and improvements to the quality of mental health services in their service area.

3. The PIHP is expected to implement service delivery protocols for the coordination and integration of services for consumers with multiple needs. These protocols are to be implemented in the beginning of the new contract period. In addition, a quality improvement initiative directed toward services for and service delivery to children and youth is a focus for this biennium. The development and implementation of plans for protocols must include a method to evaluate progress in cross-system coordination and integration of services. The impacted populations include, but are not limited to:
    a. Native American/Indian children
    b. Children served by DSHS Juvenile Rehabilitation Administration, and Children's Administration.
    c. Adults and older adults served by DSHS Aging and Adult Services Administration.
4. MHD requires compliance with state and federal non-discrimination policies and expects PIHPs to participate whenever possible in the coordination of mental health services with other systems of care. MHD is part of a Disease Management project with Medical Assistance Administration (MAA) and is monitoring the collaborative efforts regarding the management of these high risk, co-morbid conditions as documented in the client's mental health record.

C. MHD identifies certain demographic characteristics of Medicaid clients for PIHPs at the time of enrollment. When enrolling in Medicaid, beneficiaries are asked to indicate their race, ethnicity and preferred language. When provided, the information is passed into the MMIS system and on to MHD. When clients seek services at a PIHP provider, the PIHP provider checks the information the client provides with the MMIS data. On a monthly basis, the MHD requires (through its data dictionary) PIHPs to submit race, ethnicity, and the client's preferred language for consumers in or accessing services. MHD summarizes this information and makes it available to each PIHP to use in assessing translation and interpretation requirements. Using this information in combination with census data and other DSHS databases, PIHPs determine prevalent languages in their service region to fulfill document translation requirements**.** The PIHP notifies clients what services are available in their preferred language and how to access them. MHD also expects the PIHP to demonstrate that these notification mechanisms are effective.

D. An External Quality Review (EQR) of the PIHP will be conducted annually related to quality outcomes, timeliness of and access to the services covered under each contract. The MHD Quality Assurance and Improvement Team (QA&I) conducts the annual PIHP monitoring process as outlined in the required CMS protocol to insure that the PIHP is in compliance with Medicaid managed care regulatory provisions. The team will conduct interviews and client record reviews (30 per PIHP) to gather information to assess the PIHP's ability to provide oversight of client care. The information concerning federal requirements will be sent forward to the EQRO (or EQRO-like entity) for further evaluation. The EQRO will then provide CMS with the appropriate reports.

E. Two addition requirements for external quality review will be met as follows:

1. Validation of two quality improvement projects required by the State to comply with 438.240(b)(1) that were underway during the preceding 12 months. Some quality improvement may be required by the state to be continued, based on specific outcomes for a specified time period in each PIHP. For the two federally required quality improvement projects, the state's QA&I team will join with the

MHD's Performance Indicator Workgroup to oversee the conduct of these projects and to help the PIHPs prepare for project validation by the EQRO. MHD has decided to institute two statewide quality improvement projects: increasing client participation in treatment planning (a clinical indicator) and improving data quality (a non-clinical indicator). MHD will use the CMS protocol for conducting QI projects to develop the projects for each PIHP. The data from these projects will go forward to the EQRO for validation, with the required report going forward to CMS.

2. Validation of performance measures reported (as required by the State) or performance measures calculated by the State during the preceding 12 months to comply with requirements in 438.240(b)(2). The MHD Performance Indicator (PI) work group will use the required external quality review protocol to evaluate the accuracy of these performance measures, and determine the extent the PIHP followed specifications for calculating the measures. The PI workgroup has already produced two annual PI reports (2001 and 2002), and will decide if all or some of the measures are used in this process. The process the PI workgroup follows and their findings will be reviewed and validated by the EQRO.

The information gathered via the three federally mandated EQR protocols is forwarded on to the MHD EQRO for further evaluation. For the first year of this biennium, the MHD will forward data on to Washington Institute for Mental Illness Research and Training (WIMIRT) in Spokane, an EQRO-like entity. In addition to providing an EQRO report to CMS, WIMIRT will compile the information in more detail than typically expected from an EQRO to provide a training exercise in consistency and inter-rater reliability for MHD staff. Included in this waiver modification, the MHD is seeking approval to use this training and technical assistance process for both years of the biennium.

The MHD and the State Auditor will also be monitoring fraud and abuse once MHD and the PIHPs receive the requested CMS training on this subject.

F. Remedial Action. PIHPs must agree that MHD may initiate remedial action if MHD determines any of the following situations exist:

1. A problem exists in the PIHP service delivery area that negatively impacts consumers;
2. The PIHP has failed to perform any of the mental health services required in the contract;
3. The PIHP has failed to develop, produce, and/or deliver to the MHD any of the statements, reports, data accountings, claims, and/or documentation described in the contract;
4. The PIHP has failed to perform any administrative function required in the contract. 'Administrative function' is defined as any obligation other than the actual provision of mental health services;
5. The PIHP has failed to implement corrective action required by the State and within the MHD prescribed time frames.
6. MHD may impose one or more of the following remedial actions in response to findings of situations as outlined above:
   a. The MHD may require the PIHP to plan and execute corrective action. Corrective action plans include:
      1) a brief description of the finding;
      2) specific steps taken to correct the situation and a timetable for performance of specified corrective action steps;
      3) a description of the monitoring to be performed to ensure that the steps are taken;

4) A description of the monitoring to be performed that will reflect the resolution of the situation.

b. Corrective actions plans developed by the PIHP must be submitted to the MHD within 30 calendar days of notification. The MHD may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by the MHD. Corrective action plans shall be subject to approval by the MHD, which may accept the plan as submitted, accept the plan with modifications, or reject the plan as follows:
   1) require modification of any policies or procedures by the PIHP relating to the fulfillment of its obligations pursuant to the contract;
   2) Withhold one percent of the next month's capitation payment and each monthly capitation payment thereafter until the corrective action has achieved resolution. The MHD, at its sole discretion, may return all or a portion of any or all payments withheld once satisfactory resolution has been achieved;
   3) compound withholdings identified above by an additional one half or one percent for each successive month during which the remedial situation has not been resolved;
   4) Deny any incentive payment to which the PIHP might otherwise have been entitled under the contract of any other arrangement by which the MHD provides incentives.

G. Contract termination may occur in the following situations:
   1. Termination due to change in funding in the event that funding from State, federal or other source is withdrawn, reduced, or limited in any way.
   2. Termination due to change in 1915(b) Mental Health Services Waiver. DSHS may terminate this agreement, subject to re-negotiation (if applicable) under new terms and conditions.
   3. Termination for convenience. Except as otherwise provided in the contract, either party may terminate the agreement upon 90 days written notice.
   4. Termination for default. The contracting officer may terminate the agreement for default, in whole or in part, by written notice to the PIHP, if DSHS has a reasonable basis to believe that the PIHP has:
      a) Failed to meet or maintain any requirement for contracting with DSHS;
      b) failed to perform under any provision of the agreement;
      c) violated any law, regulation, rule, or ordinance applicable to the services provided under the agreement; and/or
      d) Otherwise breached any provision of condition of the agreement.

H. All mental health services covered in the State Plan are the responsibility of the PIHP and must be available and accessible to their enrollees.
   1. Benefit package
      a) Covered lives. The PIHP shall provide crisis mental health services and medically necessary mental health services to the following:
         1) Enrollees of all ages included in the 1915(b) Waiver. All Medicaid persons requesting mental health services shall be screened, assessed and authorized based on the Access to Care Standards and minimum eligibility requirements;
         2) Enrollees who reside in the PIHP service area pursuant to Contract Exhibit E;
         3) Enrolled children with "d" coupons or its legal substitute, or other evidence of Placement by DSHS, who currently reside in the PIHP service area without regard to the child's original residence;
         4) Persons who reside in the PIHP service area who are experiencing a crisis may receive mental health services regardless of financial eligibility;
         5) Persons who meet the non-Medicaid "state priority populations" as defined in RCW 71.05,

71.24, 71.34 or any successors, with special attention to children, older adults and minorities shall be served based on available resources;

6) Persons eligible for state only programs (MI, GAU) shall receive voluntary inpatient hospitalization when the PIHP has determined that such services are medically necessary. Community support services for these persons shall be provided based upon eligibility per this agreement and within available resources;
7) Persons who are mentally ill shall have access to all components of the Involuntary Treatment Act applicable to PIHPs as identified under this agreement, state law, and the 1915(b) Waiver, regardless of financial eligibility.

2. General Services. The PIHP shall ensure:
   a) The provision or the purchase of medically necessary mental health services for all enrollees in accordance with the PIHPs obligations under the contract;
      1) The PIHP shall ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;
      2) The PIHP shall ensure services are not arbitrarily denied or reduced (e.g., amount, duration or scope of a required service) solely based on the diagnosis, type of mental illness, or the enrollee's mental health condition.
   b) Enrollees can access medically necessary mental health services upon request that do not exceed the standards below. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call referral, walk-in, or written request for mental health services. The determination of eligibility shall be based on the Access to Care standards. Urgent and emergent medically necessary mental health services(e.g., crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes. The PIHP shall ensure:
      1) an intake assessment is initiated within 10 working days of the request for mental health services;
      2) Routine mental health services are offered to occur within 14 calendar days of a determination of eligibility. An extension of up to 14 calendar days is possible upon request by the enrollee of the CMHA if:
         a) the PIHP provides written justification to the MHD regarding the need for additional information; and
         b) The PIHP indicates how the extension is in the enrollees' best interest.
      3) emergent mental health services occur within 2 hours of the request for mental health services from any source;
      4) Urgent care occurs within 24 hours of the request for mental health service from any source.
   c) Each enrollee is able to choose a participating MHCP in accordance with WAS or any successors. If the enrollee does not want to make a choice, the PIHP or its designee must assign a MHCP no later than 14 working days following the request for mental health services. The enrollee may change MHCP in the first 90 days of enrollment and once during a twelve-month period for any reason. Any additional change of a MHCP during a twelve-month period may be made at the enrollee's request with justification documented by the PIHP.
   d) Enrolled children who meet the requirements of EPSDT guidelines shall receive mental health services that comply with Contract Exhibit J.
   e) Children are referred to physical health care when the MHCP determines a referral is needed based on the periodicity schedule.

f) Based on available resources, consumers receive community support, residential and employment services described in RCW 71.24.025.
g) Consumers, including children and their families, have voice in developing individualized service plans, advance directives, and crisis plans.
h) Consumer strengths, family involvement, formal/informal and natural supports are incorporated into the individualized service plan.
i) Implementation of mechanisms that promote rapid and successful reintegration of consumers back into the community from long-term placements from psychiatric hospitals and children's long term inpatient facilities which ensures the following:
    1) Designation of a MHCP as primarily responsible for coordinating the mental health care services provided to the consumer;
    2) CMHAs have the information necessary for effective continuity of care and quality improvement;
    3) Continued implementation of the Expanding Community Services (ECS) Project according to contract exhibit M or N, whichever is applicable.
    4) The PIHP shall be able to demonstrate that its community reintegration mechanisms are effective.
j) Use treatment interventions that are research-based and shown to be effective in achieving positive outcomes (e.g., wraparound, multi-systemic therapy, and intensive case management) when providing mental health services to children and youth. DSHS will plan with the PIHPs, parents, MCHAs and others (e.g., Universities, Child Welfare, families) involved in the delivery of services to children and youth to identify and establish:
    1) statewide reform in the clinical practices offered to these youths;
    2) a collaborative means to shift the practice for this population;
    3) Establish best practices and develop practice guidelines and clinician protocols. (Final report to the Secretary of DSHS from the Select Committee on Adolescents in Need of Long Term Placement, recommendation #9 for Children with Complex Mental Health Needs).

3. Psychiatric Inpatient Services: Community Hospitals. The PIHPs shall ensure:
    a) Contact with the community hospital staff occurs within three working days of a consumer's admission to a community hospital unit. The PIHP's liaison or designated CMHA shall participate with the community hospital inpatient treatment team in both treatment and discharge planning.
    b) A CMHA is designated for consumers and their families seeking community support services prior to discharge from an inpatient setting.
    c) Response to calls requesting certification of the need for psychiatric inpatient care for consumers in community hospital units occurs within two hours. AA decision concerning certification of the need for psychiatric inpatient care shall be made within twelve hours of the initial call.
    d) A physician reviews determinations of clinical appropriateness for consumers if the PIHP denies a request for authorization of a psychiatric inpatient admission.
    e) Response to appeals within fourteen calendar days if the PIHP's decision to deny payment of any portion of a psychiatric inpatient stay for consumers is appealed by the inpatient facility. The inpatient facility may appeal the PIHP's decision(s) to the MHD after all reasonable effort is made to resolve the dispute between the PIHP and the inpatient facility.
    f) Adherence to the requirements set forth in the psychiatric inpatient exhibits combined in contract Exhibit E.

g) Ensure the continued provision of community psychiatric inpatient services should a community hospital become insolvent.
h) MAA holds the contract for External Quality Review for these hospitals.

V. Access Criteria.

A. The PIHPs will provide standards for access to care so that covered services are available 24 hours a day, 7 days a week within reasonable response timeframes, and in a manner that ensures continuity of care and adequate capacity. MHD believes it is important for consumers to be seen quickly at each stage of treatment, and for care continuity to be coordinated when the consumer transitions between care or service settings. MHD has recently developed Access to Care standards which clearly defines who is seen for care; the access standards for timeliness have been incorporated into the contract. PIHPs monitor access and care continuity timeliness at six critical points:

1. At initial entry into the system, intake is initiated within 10 days of request for mental health services (to minimize the number of days from initial contact to outpatient service appointment);
2. To minimize the number of days from intake appointment to onset of initial treatment services, routine mental health services are offered to occur within 14 calendar days of a determination of eligibility (an extension of 14 additional calendar days is possible if there are extenuating circumstances and the extension is made in the interest of patient care);
3. At periodic points during treatment --at a minimum, the treatment plan must be updated every 180 days;
4. As the client transitions from outpatient to inpatient care--provider contact occurs with facility team to coordinate care and discharge planning;
5. As the client transitions from inpatient to outpatient care--to minimize the number of days from hospital discharge to first face-to-face outpatient appointment;
6. At entry into the crisis system (time from initial call to CDMHP triage)--emergent mental health services occur within 2 hours of the request for mental health services from any source. Urgent care is to occur within 24 hours of the request for mental health services from any source;
7. For services that occur in the provider's office, wait time should not exceed 1 hour beyond the scheduled appointment time.

B. Additional Access Criteria: The minimum Access to Care standards and minimum eligibility criteria will be in place to begin in August 2003. The PIHP level of care guidelines submitted to and approved by MHD are to be in place within 90 days of contract execution. The PIHP's guidelines shall be submitted to MHD for approval within 30 days of any change to content. The PIHP shall maintain its 2001-2003 Level of Care Guidelines until such time as the 2003-2005 Guidelines are approved

C. Resource and Utilization Management. The PIHP shall:

1. The PIHP must be able to demonstrate that its resource management mechanisms are effective. This includes ensuring mechanisms are in place to adjust to situations in which there is:
   a) unanticipated need for MHCP with certain types of expertise;
   b) Unanticipated limitation of the availability of such MHCP including identifying the number of MHCP whom are not accepting new enrollees.
2. Ensure the capacity to adjust the number, mix and geographic distribution of MHCP and other qualified personnel to meet access and travel standards as the population of enrollees needing mental health services shifts within the service area. Any change that results in reduced capacity must be approved in advance by the MHD.
3. Ensure the consistent application of the Access to Care standards in determining what constitutes medically necessary mental health services within the PIHP service area.
4. Ensure enrollees are notified of authorization decisions through written or oral means.

5. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less that requested or described in the individuals service plan is made by a mental health professional with the appropriate clinical expertise to make such a decision.
6. Notify the requesting CMHA, and give the enrollee written notice, of any PIHP decision that:
   a) denies a service authorization request; or
   b) Authorizes a service in an amount, duration or scope that is less than requested.
7. Ensure that mental health professionals have effective communication with enrollees with sensory impairments.
8. Ensure mental health professionals and MHCP, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:
   a) the enrollee's mental health status, or mental health treatment options, including any alternative treatment, in a culturally competent manner;
   b) any information the enrollee needs in order to decide among all relevant mental health treatment options;
   c) the risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment;
   d) the enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse treatment, and to express preferences about future treatment decisions;
   e) the enrollees right to be treated with respect and with due consideration for his or her dignity and privacy;
   f) the enrollee's right to be free from any sort of restraint or seclusion used as a mean of coercion ,discipline, convenience or retaliation;
   g) the enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;
   h) The enrollee's right to be free to exercise his or her rights, and to do so does not adversely affect the way the PIHP, CMHA of MHCP treats the enrollee.
9. For the purpose of utilization control, the PIHP may place appropriate limits on a mental health service based on criteria such as medical necessity provided the mental health services furnished can reasonably be expected to achieve their purpose. The PIHP may specify what constitutes medical necessity in a manner that is:
   a) no more restrictive than the State Medicaid program; and
   b) to the extent that the PIHP is responsible for covering mental health services related to the screening, diagnosis and treatment of mental illness;
   c) congruent with the consumer's ability to attain, maintain or regain functional capacity
10. Ensure that utilization management activities are not structured so as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any consumer.
11. Provide upon request a second opinion from a qualified mental health professional within the network. If an additional qualified mental health professional is not currently available within the network, the PIHP shall provide or pay for a mental health professional outside the network, at no cost to the consumer. The second opinion is offered to occur within 30 days of the request for a second opinion.

VI. Quality Management.

A. The PIHP conducts monitoring and reviews its ongoing quality management program to ensure continued assessment and improvements to the quality of mental health services in their service area, and to determine the effectiveness of the overall regional system of care (42 CFR 438.240). In addition, the PIHP shall:
   1. Assess the clinical appropriateness of fit between what services were needed and what services were provided;
   2. Assess the degree to which mental health services and planning incorporate consumer/family voice;
   3. Assess the degree to which mental health services are age, culturally, and linguistically competent;
   4. Assess the degree to which mental health services are provided in the least restrictive environment;
   5. Assess the degree to which needs for housing, employment and education options were met;
   6. Assess the degree to which there are appropriate linkages and integration with other formal/informal systems and settings;
   7. Assess the effectiveness of mechanisms to detect both under-utilization and over-utilization of mental health services;
   8. Assess performance and efficiency of CMHA and ascertain that their performance is within current standards for mental health;
   9. Ensure relevant grievance and fair hearing results are incorporated into system improvement;
   10. Ensure the interpretation of quality improvement feedback is conveyed to CMHAs, the advisory board and other interested parties;
   11. Measure allied system satisfaction.
B. Participate with the MHD in the implementation of the Quality Strategy.
C. Participate with the MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation shall include:
   1. providing necessary data;
   2. participating in the analysis of results and the development of system improvements based on that analysis on a statewide basis;
   3. Incorporating results into PIHP-specific quality improvement activities.
D. Participate with the MHD in completing the two Mental Health Statistics Improvement Project (MHSIP) surveys, one for adults and one for youth/families. Participation shall include, at a minimum:
   1. providing consumer contact information to the MHD;
   2. participating in the analysis of results and the development of system improvements based on that analysis on a statewide basis; and
   3. Incorporating results into PIHP-specific quality improvement activities.
E. Participate with the MHD and other PIHPs in the development and implementation of two statewide Quality Assessment and Improvement projects. These projects shall include one clinical (consumer participation in treatment) and one non-clinical (data quality).
F. Participate with the MHD in its annual review activities (e.g., PIHP certification, Medicaid managed care reviews, provider licensure and certification). At a minimum, participation shall include:
   1. submission of deliverables and other materials necessary for the team's visit prior to their arrival on site;
   2. completion of site visit protocols;
   3. Assistance in scheduling interviews and agency visits.

VII. Management Information System. The PIHP shall:

A. Provide MHD all data described in the data dictionary for the MHD Consumer Information System (MHD-CIS) (Data Dictionary), or any successor. Data shall be submitted within 60 days of the close of each calendar month. Upon receipt of the data, the MHD will generate an error report. Upon receipt of the error report, the PIHP will remedy all data errors within 30 calendar days of the receipt of the error report.

B. Demonstrate a primary and backup system for electronic submission of data requested by the MHD. This shall include the use of the Inter-Governmental Network (IGN), ISSD-approved secured Virtual Private Network (VPN), or the SHIVA toll-free telephone system. Alternate media are not acceptable.

C. Participate in MHD decisions to add or delete data elements that shall included projected cost analysis.

D. Implement changes made to the MHD data dictionary within 120 days from the date of published changes.

E. Provide annual written certification which attests, based on best knowledge, information, and belief, of the PIHP Administrator:

1. to the accuracy, completeness, and truthfulness of data;
2. that the PIHP is in compliance with this agreement;
3. To the accuracy, completeness, and truthfulness of documents specified by the MHD.

F. Ensure that the requested information is received in a manner that will allow for a timely response to inquiries from CMS, the legislature, MHD, and other parties about system operations. Such data shall be provided in a time frame developed with the MHD at the time of the request and takes into consideration the needs of the inquiring party.

VIII. Structure and Operations. Each PIHP must:

A. Purchase age, linguistic and culturally competent community mental health services for consumers who experience mental illness or who are severely emotionally disturbed. Such services will also be purchased for those they define as family (e.g., parents, foster parents, assigned/appointed guardians, siblings, caregivers and significant others) pursuant to:

1. RCW 38.52, 70.02,71.05,71.24, and 71.34, or any successors;
2. WAC 388-865 or any successors;
3. Federal Public Law 102-321 (Federal Block Grant), or any successors;
4. CFR 42CFR 438.10; 206; 207 or any successors.

B. Operate a PIHP to provide medically necessary mental health services to enrollees pursuant to:

1. Federal 1915(b) Mental Health Waiver or any successors;
2. Other provisions of Title XIX of the Social Security Act or any successors;
3. Other applicable state and federal statutes and regulations, or any successors;
4. Administrative policies, or any successors.

D. Along with its subcontractors, comply with all applicable federal statutes and regulations, whether or not a specific citation is identified in various sections of this agreement, and all amendments thereto that are in effect when the agreement is signed, or that comes into effect during the term of the agreement.

E. This includes, but is not limited to, Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. Any provisions of this agreement which conflict with state and federal statutes, or regulations, or CMS policy guidance is hereby amended to conform to the provisions of state and federal law and regulations.

F. The formal questions and answers from the Waiver renewal will be incorporated upon completion. The

PIHP shall be informed of the formal questions and given opportunity to respond along with the MHD in the development of the formal written answers.

G. This agreement, including all documents incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this agreement shall be deemed to exist or bind the parties.

H. DSHS remains the single state authority for Medicaid.

I. The Department of Social and Health Services (DSHS), Office of the State Auditor, The Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly authorized representatives, have the authority to conduct announced and unannounced:
    1. surveys;
    2. audits;
    3. reviews of compliance with licensing and certification requirements and compliance with this agreement;
    4. audits regarding the quality, appropriateness, and timeliness of mental health services of the PIHP and subcontractors;
    5. Audits and inspections of financial records of the PIHP and its subcontractors.

J. Along with its subcontractors, recognize the unique social/legal status of Indian nations; the tribes under the Supremacy clause; the Indian Commerce Clause of the United State Constitution; federal treaties; executive orders; Indian Citizens Act of 1924 statutes; state and federal court decisions; and maintain compliance with DSHS American Indian Policy 7.01, or any successor, pursuant to the Centennial Accord between the Washington State Government and the Washington Tribes.

K. Operate a mental health managed care system with necessary authority, accountability, and administrative capability for its entire geographic area.

L. Adjust to funding constraints that may further limit capacity to provide mental health services to state priority populations by planning for the need for crisis intervention and mental health services for those most in need.

M. Furnish the necessary personnel, materials, and /or mental health services and otherwise do all things necessary for, or incidental to, the performance of the work set forth here and as attached. Unless otherwise specified, the PIHP shall be responsible for performing or ensuring fiscal and program responsibilities. No subcontract will terminate the legal responsibility of the PIHP to perform the terms of this agreement.

N. Provide for the availability of crisis mental health services and medically necessary mental health services on a 24-hour, 7 days per week basis. The PIHP shall purchase crisis mental health services where the PIHP has no formal crisis service arrangements.

O. Provide all components of the Involuntary Treatment Act applicable to PIHPs, as identified in this agreement, state law, and 1915(b) waiver.

P. Ensure a sufficient number, mix, and geographic distribution of community mental health agencies (CMHA) and/or qualified personnel, including mental health care providers (MHCPs) to meet:
    a. an age appropriate range of mental health services;
    b. access to medically necessary mental health services to meet the needs of the anticipated number of enrollees; and
    c. Access and travel standards.

Q. Ensure that when enrollees must travel to service sites, they are accessible per the following standards:
    a. in rural areas, service sites are within a 30 minute drive time;
    b. in large rural geographic areas, sites are available within a 90 minute commute time;
    c. in Urban areas, service sites are accessible by public transportation, with the total trip including

transfers not to exceed 90 minutes each way;

d. travel standards do not apply:
    1) when a consumer chooses to use service sites that require travel beyond the travel standard;
    2) to psychiatric inpatient services;
    3) Under exceptional circumstances (e.g., inclement weather, hazardous road conditions due to accidents or road construction, public transit shortages, delayed ferry service).

R. Purchase medically necessary mental health services pursuant to this agreement outside of the PIHP service area in a timely manner if the CMHA and/or qualified personnel is unable to provide the services covered under this agreement. The PIHP shall continue to pay for medically necessary mental health services outside the service area until the PIHP is able to provide them within its service area.

S. Include consumer and family voice in planning, implementation, and evaluation of the public mental health system.

IX. Information Requirements

A. Maintain and comply with an Advance Directive policy that respects consumer's advance directives for psychiatric care. If the state law changes, the MHD will send notice to the PIHP who shall then ensure the provision of notice to consumers within 90 days of the change.

B. Ensure Healthy Options enrollees are informed of their choice to receive mental health services either through the PIHP on the Healthy Options enrollee's managed care plan and in a manner that in no way limits or directs their choice.

C. Ensure enrollee information complies with 42 CFR438.100 (a) 2, 438.6(l)(3), or any successors. In addition, the PIHP shall:

1. have mechanisms in place to notify enrollees:
    a. that oral interpretation in any language and written interpretation in prevalent languages as called out by DSHS (i.e., Cambodian, Cantonese, Mandarin, Korean, Laotian, Russian, Spanish, and Vietnamese) is available;
    b. How to access these services. The PIHP shall be able to demonstrate that its notification mechanisms are effective.
2. make available and provide:
    a. enrollee general rights;
    b. oral interpretation services free of change to the enrollee;
    c. information about benefits and authorization requirements;
    d. identification of MHCPs who are not accepting new enrollees upon request;
    e. written materials that are available when requested in alternative formats and easily understood by enrollees;
    f. additional annual information upon request from enrollees, including:
        a) CMHA licensure, certification and accreditation status;
        b) Information that includes, but is not limited to, education, licensure, and Board certification/re-certification of mental health professionals and MHCPs.
3. Collaborate with MHD to develop the required enrollee information;
4. Ensure its Grievance process complies with MHD's approved policy and WAC 388-865-0255 or any successors. The MHD Grievance Policy is attached.

X. Additional Care Management Requirements. The PIHP must:

A. Incorporate the Access to Care standards within the PIHP's Level of Care Guidelines as they pertain to minimum eligibility criteria for enrollee access to outpatient mental health services. Guidelines must include length of stay (LOS) and discharge criteria.

B. Implement mechanisms to ensure the consistent application and utilization of its Level of Care. The

PIHP shall be able to demonstrate that its mechanisms are effective.

C. Participate wherever possible in the coordination of mental health services with other systems of care. These include, but are not limited to, physical health care, Alcohol and Substance Abuse, Developmental Disabilities, Child Welfare, Juvenile Justice, Aging and Disabilities Services Administration, Tribes, Vocational Rehabilitation, jails, corrections, informal/natural supports, and education. The PIHP will also:
    1. Implement service delivery protocols developed under the 01-03 agreement for the coordination and integration of services for children and adults/older adults.
    2. Comply with published directives from MHD when the PIHP or its subcontractors are unable to resolve local disputes with other service systems (e.g., Healthy Options, other DSHS administrations) regarding service or cost responsibilities.

D. Ensure it does not:
    1. operate any physician incentive plan as described in 42 CFR 422.208;
    2. Does not contract with any subcontractor operating such a plan. If the PIHP desires to implement any form of physician incentive plan, the PIHP shall provide 60 days written notice to the MHD and shall comply with all requirements of 42 CFR 438.6(h).

E. Ensure enrollees are not held liable for any of the following:
    1. Community psychiatric hospitals in the case of insolvency. The PIHPs are specifically exempt from the requirements of 42 CFR 438 regarding solvency.
    2. Covered mental health services provided to the enrollee for which:
        a. the State does not pay the PIHP; or
        b. The PIHP does not pay the MHCP or CMHA that furnishes the service under a contract, referral or other arrangement, to the extent those payments are in excess of the amount the enrollee would owe if the PIHP provided the services directly.

F. Have administrative and management procedures in place that are designed to guard against fraud and abuse including:
    1. a mandatory compliance plan;
    2. written policies, procedures, and standards of conduct that articulate the PIHP's commitment to comply with all applicable federal and state standards;
    3. designation of a compliance officer and a compliance committee that is accountable to senior management;
    4. Effective training and education for the compliance officer, staff of the RSN, and MHD selected staff of the CMHAs. The MHD shall request this training be provided by CMS to ensure compliance with their guidelines and expectations including the use of the List of Excluded Individuals (LEIE) and CMS Publication 69 or their equivalent. MHD will notify the PIHP when this training is planned;
    5. Effective lines of communication between the compliance officer, the PIHP, and the PIHP's network of CMHAs;
    6. Enforcement of standards through well-publicized disciplinary guidelines;
    7. Provision of internal monitoring and auditing;
    8. Provision for prompt response to detected offenses and for development of corrective action initiatives.

G. Notify the MHD of any incident where the potential for negative media coverage exists (e.g., unexpected death of a consumer served by the PIHP, loss of crisis lines, loss of service or residential sites, natural disasters or acts of terrorism);
    1. Notification shall be made to the Mental Health Services chief or his/her designee during the

business day in which the PIHP becomes aware of the event. If the event occurs after business hours, notice shall be given as soon as possible during the next business day.

2. Notification shall include:
   a. a description of the event;
   b. any actions taken in response to the event;
   c. the purpose or end for which any action was taken'
   d. Any implications to the service delivery system.
3. Within 2 weeks of the original report, provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

H. Respond in a timely manner to requests to provide information necessary to respond to inquiries from DSHS, CMS, MHD or other entities;

I. Ensure plans or reports required by this agreement, including Exhibit F (Deliverables), are provided to MHD in compliance with the timelines and/or formats indicated.

J. Implement mechanisms to ensure the selection and retention of a network that is licensed or certified by the state. The PIHP shall be able to demonstrate that its mechanisms are effective.

K. Insure there is no discrimination with respect to:
   a. the participation, reimbursement or indemnification of any CMHA that is acting within the scope of its license, or certification under applicable state law, solely on the basis of that license or certification;
   b. Particular CMHAs who serve high-risk mental health consumers of specialize in mental health conditions that require costly treatment.

L. Provide written notice to individuals or groups of CMHAs of the reason for the PIHP's decision if they are not selected for the PIHP's CMHA network. All contracts with CMHAs shall comply with 42 CFR 438.214.

M. Notify the MHD 30 days in advance of public notice before the PIHP terminates any of its CMHA subcontracts. If the PIHP terminates a CMHA contract in less than 3o days, the PIHP shall notify the MHD as soon as there is a determination to terminate the subcontract and in advance of public notice.

N. PIHP and Subcontractors
1. The PIHP and all levels of subcontractors shall comply with all applicable state and federal statutes, rules and recommendations, or any successors. In addition, the PIHP will:
   a. Ensure distribution of enrollee notification of applicable changes in state law (e.g., Advance Directives) upon receipt of notice from the MHD;
   b. Ensure a process is in place to demonstrate that all third-party resources are identified and pursued in accordance with Medicaid being the payer of last resort;
   c. Oversee, be accountable for, and monitor all functions and responsibilities delegated to a subcontractor on an ongoing basis including formal reviews;
   d. Evaluate subcontractors' ability to perform delegated activities prior to any delegation of responsibility or authority to the subcontractor;
   e. Ensure enrollee access and mental health services are equal to or greater than access and services would be under Medicaid fee for service.
2. Ensure that all subcontracts are in writing and that subcontracts specify all duties, reports, and responsibilities delegated under this agreement. Those written subcontracts shall:
   a. Require that the subcontractor neither employs any person or contracts with any person or CMHA excluded from participation in federal health care programs under wither section 1128 or section 1128A of the Social Security Act, or debarred or suspended per this agreement's general terms and conditions;

b. Require subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of services to be performed under this agreement;
c. Require compliance with state and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and DSHS Administrative policies (e.g., 7.01, 7.20, 7.21 or any successors) to the extent they are applicable to the subcontract;
d. Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract;
e. Require that the contractor correct any areas of deficiencies in the subcontractor's performance that are identified by the PIHP;
f. Require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to enrollees who had been assigned to the affected MHCP.

X. State Responsibilities for Oversight of the Quality Strategy

A. Quality Strategy reviews

1. MHD will use its own quality management infrastructure to evaluate the effectiveness of the Quality Strategy.
   a. The Performance Data Group (PDG)
      1) Membership from the Performance Indicator (PI) Workgroup and the Quality Steering Committee (QSC). The PDG membership includes stakeholders (e.g., consumers, family members, representatives from consumer advocacy groups), staff from PIHPs and CMHAs, and MHD staff (to include the quality coordinators from MHD HQ and all three facilities).
      2) The primary role of this group is to review system-wide performance data as well as data collected from the CMS EQRO protocols: MHD's QA&I team's monitoring reviews as well as data collected in support of the performance measure and quality improvement protocols. This review is done at the same time the data is sent on to the EQRO for evaluation and validation.
      3) A secondary role of this group is to review QI project information from the IDG and use it to inform ongoing data review work. PDG develops new performance indicators as a result of this review.
      4) The group presently meets quarterly, and makes recommendations to the MHD Quality Council (the MHD Management Team.
   b. The Implementation and Design Group (IDG) was formed to:
      1) Membership includes QSC members, PDG members, and members from standing MHD stakeholder groups (e.g., WAC rewrite, Advisory Council, Consumer Roundtable).
      2) Design and implement QI efforts (to include timelines and outcome measures) in response to system-wide priorities set by the Quality Council after reviewing PDG recommendations;
      3) Sends QI project information to the PDG and communicates the QI project information to constituency groups.
      4) The group meets monthly.
   c. The MHD Quality Council:
      1) Reviews recommendations from the PDG and prioritizes them.
      2) Send priorities to IDG for QI project development.
      3) Reviews EQRO and CMS reports
      4) Reviews the Quality Strategy every six months after reviewing PDG recommendations and EQRO /CMS reports.

B. Communication of Quality Management work (to include the Quality Strategy) to the mental health

community-at-large.

1. Presentations of initial quality strategy drafts were made to the membership of regularly meeting groups such as RSNs, Washington County Executives, Mental Health Planning and Advisory Council,, Washington County Mental Health Agency Council, Performance Indicator Group, Quality Steering Committee, and SAFE-Washington. Feedback from these groups was incorporated into the reviewed draft, and new drafts were released to internal and external stakeholders.
2. The overall strategy will be released in its entirety for public comment before its final adoption, and will undergo reviews every six months by MHD and the Quality Management infrastructure. To broadly solicit feedback, the strategy will be posted on the MHD Internet. AS information and performance data is obtained, it will also be posted.
3. The MHD quality strategy is viewed as a 'living' document, responsive to the needs of customers and stakeholders and sensitive to system change. Further changes to the quality strategy will be made as the monitoring and evaluation process evolves.

End of Attachment C.I.a.

b.___Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires.

a._x_[Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).

b._x_[Required] The State must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

c._x_[Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

d._x_[Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03. *This is a new requirement for PIHPs and not in effect until 3/25/04.*

1. Please specify the name of the entity:

2. The entity type is:
   (a)___ A Peer Review Organization (PRO).
   (b)___ A private accreditation organization approved by CMS.
   (c)___ A PRO-like entity approved by CMS.

   Per the regulations, within the MHD, staff will be able to utilize the three required EQR protocols beginning in FY04. Per the regulations release in January 03, the EQRO function is not required before 3/25/04. This is a new process for mental health. PIHPs and these protocols do not fit well with community mental health, therefore the state is requesting the following: 1)

training by CMS staff for the implementation of the protocols to mental health staff within the first three months of the waiver modification; and 2) that the MHD requests authority to waive EQRO requirement438.354 and be allowed for this waiver modification to use the eastern branch of the Washington Institute for Mental Illness Training and Research (WIMRT) as a proxy external review organization for the first year of this requirement 438.354 (find correct citation).

MHD would send the information collected through the EQR process to WIMIRT, and receive feedback about the quality and completeness of the information, as well as a report combining all of the EQR information with our quality strategy and strategic plan. The reasons behind this request are: 1*)* we have not used these mandated protocols before and would benefit from WIMRT review of our efforts; 2) it will be important to measure the consistency of the QA & I review team with regard to application of the protocols; 3*)* to see the type of reports that can be generated by an outside entity on th  orkings of the various systems contracting with the MHD; and finally, 4) the regulations were released too late for the MHD to include the state cost of this in their legislative budget request and therefore must be able to complete this task in the most cost-efficient manner.

We are selecting WIMRT to assist with this effort because they are very familiar with the public mental health system in Washington. They have a history of providing technical assistance to Washington's mental health system and will be widely accepted. WIMRT has staff who are skilled and have expertise in EQRO activities. WIMRT staff will be able to attend the training requested of CMS with MHD and then be able to provide us with technical assistance over the course of this modification.

This initial process will be the most cost effective manner in which to implement this new requirement saving both the state and CMS funds as the protocols are tested and adjusted. After the two-year test (one year before they are required and one year after) the MHD will issue a request for proposal for an EQRO.

For community psychiatric inpatient hospital services the MHD will work with the MAA to assure the information is captured.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

e._**x**_ The State includes required internal quality assessment and performance improvement (QAPI) standards in its contracts with MCOs and PIHPs.

f.___ The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1.___ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.

2._**x**_ [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

Per the above, this will be monitored as part of the review of the system.

3._**x**_ Conducts monitoring activities using (check all that apply):

(a)_**x**_ State Medicaid agency personnel

(b)___ Other State government personnel (please specify):

(c)_**x**_ A non-State agency contractor (please specify):

As part of quality improvement, the MHD's QA & I team contracts with one consumer and one parent of a minor to provide on-site monitoring. They collect information on respondent's perceptions of consumer involvement at the RSN level. This survey responds to consumer satisfaction concerns MHD was finding through MHSIP and/or through the administrative tool regarding consumer voice in planning. They are looking directly at stakeholder groups (e.g., providers, RSN staff, family members, and advisory board members) participation in PIHP processes and how well the PIHP is meeting state expectations for involving consumers.

In addition, the MHD has an Office of Consumer Affairs which sponsors both a Consumer Roundtable and a state wide parent organization (SAFE-WA) to hear directly from consumers and families. The Roundtable had membership of consumers receiving public mental health services in each of the fourteen PIHPs. SAFE-WA membership is representative of the twelve parent organizations statewide. Both of these groups provide direct input to the MHD's management team.

4.___ Other (please specify):

g.N/A for PIHP__[Required] The State has established intermediate sanctions that it may impose.

h._x_[Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement .

II. Access Standards

Coverage and Authorization of Services

Previous Waiver Period

a._x_[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

PIHPs are required to provide services comparable in scope and intensity to the state plan rehabilitation services and community inpatient services for adults and children. PIHPs must also

ensure system capacity to provide a full range of mental health services to meet the individual enrollee's needs in a way that provides for seamless coordination and continuity of mental health services creating the least amount of disruption in the enrollee's life and supports recovery and reintegration to their community.

The MHD monitors the provision of mental health services in a variety of ways. In addition to the annual on-site monitoring activities and the meetings with stakeholders, there is additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys.

During this period the advocates report the growing positive impact of consumer voice in their treatment as well as development of the system. The on-site monitoring team report that services are within the acceptable standards. Acceptable standards are 90% score on the respective licensing sections and WAC requirements. The tools (interpretive guidelines) used by the QA & I team have been provided to CMS. The team also found a definition conflict between the WAC and the contract. These conflicting definitions have been sent to the proper sections for corrections and will be clearer in the upcoming waiver and as defined in the Access to Care Standards.

Through the adult consumer survey, seventy-eight percent of the participants said they were "mostly" or "very satisfied" with the Quality and Appropriateness of their mental health services. Female participants and those participants between the ages of 18 and 21 years of age demonstrated a higher level of satisfaction. No statistically significant differences occurred among ethnic minorities. Seventy-eight percent of the participants said they were mostly or very satisfied with access to mental health services. Those who were 60-75 years of age had higher satisfaction with access than did those 21-40 years of age. No statistically significant differences occurred among different genders or ethnic minorities. The second child survey is completed and the toolkit and report are being written. These will be published and available in the spring of 2003.

Upcoming Waiver Period -- Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs,PIHPs, and PAHPs:

a. _x_ [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

b. _x_ [Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

c. _x_ [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

The MHD will use the definition in WAC 388-865-0150, or its successor:

"Medical necessity" or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to: 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

d._**x**_[Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

e._**x**_[Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

f._**x**_[Required] Require that the MCO,PIHP, and PAHP consult with the requesting ~~provider~~ *community mental health agency* when appropriate.

g._**x**_[Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

h._**x**_[Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

i._**x**_[Required] Require that the MCO,PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee *or the MHCP (per 438 requirement)* requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest. *Mental Health access standards are more stringent than this requirement they are 2 hours for emergent, 24 hours for urgent and 14 days for routine.*

j.___Other (please describe):

III. Structure and Operation Standards

Provider Selection

Previous Waiver Period

[Required for all related items checked in previous waiver request] Please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

The MHD has not received any notice from a community mental health agency with regards to selection over this waiver period. Again, the MHD licenses the CMHAs.

Upcoming Waiver Period

The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes or procedures that the State includes in its policy

a. **x** [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of ~~providers~~ *Community Mental Health Agencies*.

b. **x** [Required] Each MCO, PIHP, PAHP must not discriminate against particular ~~providers~~ *Community Mental Health Agencies* that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated. *As stated in the reason for choosing the RSNs to be the PIHP, their long history of experience in administering mental health programs, makes them the most knowledgeable about the comprehensive needs of the high-risk populations included in this managed mental health care system.*

c. ___ Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

d. ___ Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. ___ Initial credentialing

2. ___ Performance indicators, including those obtained through the following (check all that apply):

   (a) ___ The quality assessment and performance improvement program

   (b) ___ The utilization management system

   (c) ___ The grievance system

   (d) ___ Enrollee satisfaction surveys

(e)_ _ Other MCO/PIHP/PAHP activities as specified by the State.

e.___Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State _____

f.___Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g.___Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h.___Other (please describe):

IV. Subcontractual Relationships and Delegation

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver period, 1999 Waiver Renewal Preprint].

The MHD reviewed samples of model subcontracts from each of the 14 RSNs and found them to generally be in compliance with requirements found in the 01-03 biennial contract. If the samples were found to contain deficiencies the RSNs were required to amend their subcontracts.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

a.___Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2.___ All model subcontracts and addendum

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b._x_[Required] Monitors to ensure that MCOs,PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

c._x_[Required] Requires agreements to be in writing and to specify the delegated activities.

d._x_[Required] Requires agreements to specify reporting requirements.

e._x_[Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

f._x_[Required] Ensures that MCOs,PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.

g._x_[Required] Monitors to ensures that MCOs,PIHPs, and PAHPs formally review the entity's performance *on an annual basis.* ~~according to a periodic schedule established by the State.~~

h._x_[Required] Ensures that MCOs,PIHPs, and PAHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i._x_[Required] Requires MCOs,PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

j.___ Other (please explain):

V. Measurement and Improvement Standards

Practice Guidelines

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

The state requests the authority to waive regulation 438.236. The state and its contractors will be reviewing and possibly adapting some of the guidelines by APA distributed in the last 2 years. If granted, the MHD will submit a status report in the next waiver renewal.

a.___[Required] Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

b.___[Required] Guidelines consider the needs of the MCO's,PIHP's or PAHP's enrollees.

c.___[Required] Guidelines are developed in consultation with contracting health professionals.

d.___[Required] Guidelines are reviewed and updated periodically.

e.___[Required] Guidelines are disseminated to all affected providers, and, upon request to enrollees and potnetial enrollees.

f.___[Required] Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g.___Other (please explain):

Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a._**x**__[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renewal Preprint]. Please break down monitoring results by subpopulations if available.

NA - not required of PHPs last cycle however, the RSNs have identified quality projects that the state monitors. The review of that monitoring will be included in the waiver renewal.

b**.**___The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

This modification occurs before the end of the two year cycle. The results of the RSNs performance improvement projects prior to the requirements of 438 will be reported on in the renewal.

Upcoming Waiver Period- The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

a._**x**_[Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes: These are not required until 8/13/03 therefore, our review is not until 8/13/04.

1.___ The MCO's and PIHP's performance on the standard measures on which it is required to report.

2.___ The results of each MCO's and PIHP's performance improvement projects.

b.___Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have:

1.___ A policy making body which oversees the QAPI

2.___ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3.___ Active participation by providers and consumers

4.___ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

c._x_[Required] Each MCO and PIHP must have in effect mechanisms to detect both under utilization and over utilization of *mental health* services. Please describe these mechanisms:

The PIHP must have documented procedures: to identify at the RSN level over and under utilization; to require CMHA to have their own procedures that the RSNs monitor at time of contract compliance visits, to further investigate the PIHP-level instances, and to monitor the utilization over time of those cases so identified.

Additionally, they may use IS data to identify over and underutilizers, then discuss the specific cases with the CMHA. Some RSNs as a quality management tool, may review 1% or 500 charts whichever is the least to detect both over and under utilization of service.

d._x__[Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. Please describe these mechanisms:

Please see the response to special health care needs

e._x_[Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

Please see Attachment C.VI.b. - Data Dictionary and Exhibit B - DRAFT Performance Indicator Report.

Performance Improvement Projects

f._x_ [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on *mental* health outcomes and enrollee satisfaction.

g.___ Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

h._x__[Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

This is a new requirement for the PIHPs. The PIHPs and the MHD have agreed upon one clinical and one non-clinical QAPI to be statewide for each RSN. The clinical indicator will be consumer participation in treatment, the non-clinical will be data quality.

Clinical Indicator:

The recommendation from the PI workgroup for the statewide clinical indicator was a focus on Consumer Participation in Treatment. This indicator was chosen for several reasons. Washington's mental health system values consumer voice and participation and this indicator examines how well these values are being translated into practice. Data is collected through a yearly survey and Quality Assurance and Improvement (QA/I) reviews. These two tools can be easily tapped and used for a performance indicator.

In fact, the MHD has done much work with the PI workgroup in previous years to create a report based on the consumer surveys. Because this information is already collected on an annual basis data is available to establish baselines. Finally, this indicator was chosen because it is a treatment practice that should be unaffected by the anticipated changes that will take place due to the Access to Care Standards and minimum eligibility criteria.

Measuring Participation in Treatment: Two data sources will be used to monitor this indicator. (1) The MHSIP consumer surveys and (2) data collected during the annual Quality Assurance & Improvement reviews.

The MHSIP family/youth survey and the MHSIP adult survey are collected biannually. The family/youth survey was conducted in 2000 and 2002 and the adult survey was conducted in 2001. Surveys are conducted on a random sample of mental health consumers stratified by RSN and age. The Washington Institute conducts the MHSIP surveys via telephone using a CATI.

The QA/I teams visit RSNs annually to conduct quality and licensing reviews. One of the areas examined by the review teams is consumer participation in treatment. Evidence of consumer participation in treatment involves finding direct quotes from consumers contained in medical records or charts.

Monitoring & Implementing Improvement Strategies: The MHD will develop a strategy to convey the survey results and the QA/I findings to each individual RSN. The RSNs will be responsible for developing and implementing a quality improvement plan to improve or sustain the indicator and make this plan available to the MHD for review and monitoring.

Non-Clinical Indicator:

The PI workgroup decided that data quality would be the focus of the non-clinical indicator. The Information System Data Evaluation Committee(ISDEC), because of their knowledge and expertise in this area, were asked to define this indicator. They focused on the new Health Insurance Portability and Accountability Act (HIPAA) standards for data transmission. Focusing on the 837P data standards the group agreed on one indicator that will be reported by all RSNs as their non-clinical indicator:

Measuring Data Transmission: RSNs will monitor the transmission of 837P data to the MHD starting October 2003. Currently RSNs are able to monitor their transmissions to the MHD-Consumer Information System. As the IS system is modified for HIPAA, a mechanism will be put in place so that RSNs will still be able to monitor their data transmission. RSNs will record the percentage of transactions which meet the 60-day reporting window set forth in contract. By July 2004, at least 50% of all transactions should meet the 60-day reporting window.

Monitoring & Implementing Improvement Strategies: The RSNs will be responsible for developing and implementing a quality improvement plan to improve or sustain the indicator and make this plan available to the MHD for review and monitoring.

i._**x**_[Required] Each MCO and PIHP must measure performance using objective quality indicators.

j._**x**_[Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

k._**x**_[Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

l._**x**_Each MCO and PIHP must correct significant systemic problems that come to its attention through ~~internal surveillance~~ *monitoring*, complaints, or other mechanisms.

m._**x**_MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

n.___Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

o.___Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

p.___Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

q.___Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

r.___Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.

s.___Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

t.___Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

u.___Other (please describe):

VI. Mental Health Information Systems

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The RSNs submit data and error reports within acceptable standards. The Information System Data and Evaluation Committee (ISDEC) continues to meet and facilitate quality improvements. The MHD and the RSNs are working to become HIPAA compliant including attending training and conferences.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs and PIHPs maintain a *mental* health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

a._**x**_[Required] Provide information on

1._**x**_ Utilization,

2._**x**_ Grievances and appeals, *not through the IS system but through other reporting.*

3.___ Disenrollment for reasons other than loss of Medicaid eligibility.

b._**x**_[Required] Collect data on enrollee and ~~provider~~ *CMHA* characteristics as specified by the State. *The Data dictionary is attached as Attachment C.VI.b.*

Attachment C.VI.b.

Mental Health Division Consumer Information System (MHD-CIS) Data Dictionary

VERSION 3.0

Effective: October 17, 2003

Department of Social and Health Services
Mental Health Division
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This Data Dictionary documents transactions submitted by the Regional Support Networks to the Mental Health Division's Consumer Information System.

For several months, from the fall of 2002 through spring of 2003, the Information System Data Evaluation Committee (ISDEC) formed a small workgroup with a cross section of RSNs represented. This group was formed to address the MHD-CIS Data Dictionary changes required to become compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The Chairperson of the Performance Indicator (PI) workgroup participated in or reviewed the small workgroup's efforts to ensure PI concerns or requirements were met as well.

The work of this small workgroup was presented to the full ISDEC for review and adjustments with the final Data Dictionary document then made available to the RSN Administrators for their review. The last step is approval from MHD Management and the Data Dictionary is then referred to by contract.

SUMMARY OF CHANGES

Transaction 076.01 Community Hospital Authorization to be phased out of service. Inpatient data to be obtained from MAA reporting.

Transaction 075.01 Community Hospital Payment Summary to be phased out of service. RSNs will not pay hospitals directly

Transaction 070.04 E&T Inpatient Service to be phased out of service and replaced by HIPAA 837I.

Transaction 120.03 Outpatient Service to be phased out of service and replaced by HIPAA 837P.

These new transactions are compliant with HIPAA regulations. However Trading Partner Agreements between the RSNs and MHD may be used to limit the amount of data required or define technical interface specifications. Trading Partner Agreements are an appendix to this Data Dictionary and are subject to further ISDEC recommended refinement and revision on technical specifications pending full implementation of the HIPAA compliant transactions.

Thanks and appreciation should go to the PI Chairman and ISDEC members for their hard work and cooperation in creating this 2003 MHD-CIS Data Dictionary.

Reporting Expectations

Reporting RSNs shall provide to the MHD all data described in the Data Dictionary and HIPAA Trading Partner Agreements for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference. Data shall be submitted within 60 days of the close of each calendar month. Upon the receipt of the data, the MHD will generate an error report. The error report will identify errors and warnings (missing or questionable data values). The reporting RSN shall remedy all data errors within 30 calendar days of the receipt of an error report. The MHD will also monitor the quality of the data throughout the fiscal year. All transactions will be final 180 days after the close of the submission month. Once transactions are final, the reporting RSN shall be liable for any costs associated with additional data processing.

For the following data related to the provision of inpatient services, the conditions in the above paragraph apply, except that this data is not final until 18 months after the close of the submission month.

Comply with HIPAA implementation requirements and standards (e.g., data collection, submission, privacy, and security).

Implement changes made to the MHD data dictionary as required. This version of the Data Dictionary must be implemented by 10/17/03 to meet federal HIPAA regulations. For subsequent versions, the reporting RSN shall have 120 days from the date of published changes to modify their data system.

Ensure that the MHD receives requested information in a manner that will allow for a timely response to inquiries from CMS, the legislature, and other parties about system operations. Such data shall be provided in a time frame developed with the MHD at the time of the request and that takes into consideration the needs of the inquiring party.

RSN reporting of Community Hospital Services paid directly by an RSN have yet to be fully analyzed. It was not expected for this business practice to continue when the initial HIPAA analysis and preparation of this version of the Data Dictionary was done. However, should the practice continue or be adopted by other RSNs, additional work would be necessary to review the 837I and possibly a HIPAA 835 transaction content. In this case, new transaction requirements could be published as part of Trading Partner Agreements. In addition to Inpatient Service information, MHD fiscal will need the equivalent of the following data elements: Amount Paid by Medicare, Authorization Number, Date Paid, Discharge Date, Reimbursement Amount, Total Claim charge, Total Recipient Payment, and Total 3rd Party Reimbursement Amount.

Implementation Schedule

Note: MHD-CIS is planning on processing HIPAA transactions on or before 10/17/03. This will be a phased implementation depending on RSN's ability to send the transaction and MHD's ability to receive and process it. Four transactions are being phased out of service, two of them being replaced by HIPAA Complaint Transactions. Three other transactions may need internal code modification due to HIPAA Implementation; however, these changes should not require change to the transaction format.

Transaction	ID	Comments
Cascade Delete	131.02	Minimum internal change – to reflect new and removed transactions.
Cascade Merge	130.02	No change
Case Manager	100.01	No change.
CDMHP Investigation	160.02	No change.
Clear Month of Service	077.02	Minimal Change. This allows the removal of inpatient and/or outpatient services for a given month so the RSN can resubmit a given month.
Community Hospital Authorization	076.01	To be **phased out** of use for services authorized after October 17, 2003. RSNs have elected to not report Community Hospital Authorizations. Inpatient Encounter information is to be taken from MAA billing.
Community Hospital Payment Summary	075.01	To be **phased out** of use after October 17, 2003. This transaction was for RSNs that paid Community Hospitals directly. This is no longer a business practice.
Consumer Demographics	020.05	No changes.
Consumer Periodics	035.06	Minimal change. Diagnosis is now optional in this transaction.
Consumer's Case Manager	011.01	No change.
E&T Inpatient Service	070.04	To be **phased out** and replaced by HIPAA Compliant 837I.
HIPAA 837 Institutional (E&T Inpatient Service)	837I	**New HIPAA Standard Transaction** replacing 070.04 Trading Partner Agreements to identify minimum data
HIPAA 837 Professional (Outpatient Service)	837P	**New HIPAA Standard Transaction** replacing 120.03 Trading Partner Agreements to identify minimum data.
Header	000.01	No change.
Inpatient Services	070.03	Discontinued with the previous Data Dictionary. Available with special MHD/MIS permission for correction of pre 2002 E&T and Inpatient Services.
ITA Hearing	162.02	No change.
Monthly Case Status	035.04	Discontinued for consumers who receive outpatient services after January 1, 2002.
Outpatient Service	120.03	To be **phased out** and replaced by HIPAA Compliant 837P.

2003 Data Dictionary Changes
Data Element Change Summary

Data Element	Type of Change				Summary of Change
	HIPAA	Sharpen Focus	Discard Element	Add Element	
Admission Date	X				HIPAA 837I
Amount Paid by Medicare	X				HIPAA 837I COB and possibly HIPAA 835 Requirement for inpatient billing information when the RSN pays the community hospital directly.
Authorization Number	X				HIPAA 837I COB and possibly HIPAA 835
Claim Submit Identifier	X				HIPAA 837P and 837I
CPT Code/HCPCS	X				HIPAA 837P and 837I
Date Paid	X				HIPAA 837I COB and possibly HIPAA 835
Diagnosis	X	X			HIPAA 837P, 837I AND optionally used in Consumer Periodics as most recent diagnosis within reporting period.
Discharge Date	X				HIPAA 837I and 835 if needed.
Discharge Disposition	X				To be phased out of service with the Community Hospital Authorization Transaction.
DRG Code	X				To be phased out of service with the Community Hospital Authorization Transaction.
EPSDT Indicator	X				HIPAA 837P
Health Care Service Location	X				HIPAA 837P
Legal Status	X				HIPAA 837I
Minutes of Service	X				HIPAA 837P
Person Identifier Code	X				HIPAA 837P
Provider Number	X				HIPAA 837I COB and possibly HIPAA 835
Reimbursement Amount	X				HIPAA 837I COB and possibly HIPAA 835

RSN at Discharge	X				To be phased out of service with the Community Hospital Authorization Transaction.
Service Date	X				HIPAA 837P and 837I
Total Claim Charge	X				HIPAA 837I COB and possibly HIPAA 835
Total Recipient Payment	X				HIPAA 837I COB and possibly HIPAA 835
Total Third Party Payment Amount	X				HIPAA 837I COB and possibly HIPAA 835

NOTE: There are a number of Data Elements identified above as related to the HIPAA 837I COB and 835 Transactions. If the business practice of an RSN directly paying for hospital inpatient services rather than submitting claims to Medical Assistance continues or is revised, the 837I and 835 Transaction may be needed. They would replace the Community Hospital Payment Summary Transaction (075.01), which is to be phased out of service. The COB portion of a HIPAA 837I may meet the fiscal data requirements but further will be needed. If necessary, new transaction specifications can be added as part of Trading Partner Agreements.

MHD-CIS Data Dictionary Transactions

Last update: DRAFT for 2003

Status: Production	**Version:** 1	**ID:** 10018

Transaction: Cascade Delete (Full/Partial)

Effective Date: 1/1/2000

Definition:
This transaction allows for the mass deletion of records for a given consumer. There are two types of cascade delete. The first will eliminate all information previously reported. This is referred to as a "Full Cascade Delete". The second type will delete that information which pertains to a specific agency. This is referred to as a "Partial Cascade Delete".

Full Cascade Delete: This type of delete will remove all information about a consumer. Once processed, the Consumer ID will be voided and not available for future processing. This type of delete requires the authorization of the RSN Administrator and the MHD Chief of Information Services. The RSN Administrator may delegate his/her authority to authorize Full Cascade Deletes to someone who maintains their information system. The authorization must be presented to the MHD Chief of Information Services. This authorization must contain the reason for the deletes, the number of deletes that will be processed, a timeframe when the delete transactions will be submitted, and a contact for coordinating the actual processing of these delete transactions. Upon approval by the MHD Chief of Information Services, the RSN will be contacted and a time frame will be coordinated for the actual processing of this transaction.

Partial Cascade Delete: This type of delete will not require prior authorization. It is limited to a single agency as identified by the Reporting Unit ID. Partial delete will delete a specific consumer's records for the following transactions: 1) Consumer's Case Manager 2) Inpatient Service and 3) Outpatient Service.

NOTE: There is no action code in this transaction!

Transaction ID: Value "131.02"

Primary Key: Reporting Unit ID *(RSN ID)*
Consumer ID *(The ID to be deleted)*

Body: Reporting Unit ID *(Leave blank or null for a Full Cascade Delete; enter the Agency ID for a Partial Cascade Delete)*

Edits:

Message Number	Message
23107	Error: RSN or Contractor ID not valid. Transaction not posted.

23306	Soft Error: Consumer ID for Contractor has been previously voided. Transaction not posted.

Status: Production	**Version:** 1.01	**ID:** 10015

Transaction: Cascade Merge

Effective Date: 1/1/1998

Definition:
This transaction will void a Consumer ID and bar its use in the future. A Consumer ID is voided when the Contractor has established two different identifiers for a single person. The Contractor must identify the Consumer ID to be voided and also identify the Consumer ID to reference in its place.

NOTE: There is no action code in this transaction!

Transaction ID: Value "130.02"

Primary Key: Reporting Unit ID *(RSN)*
Consumer ID *(The ID to be voided)*
Body: (Referenced) Consumer ID *(Required - The ID for future reference)*

Edits:

Message Number	Message
23008	Error: Primary Key Fields cannot be bland or null. Transaction not posted.
22007	Error: Referenced Consumer ID cannot be blank or null. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
23306	Soft Error: Consumer ID for Contractor has been previously voided. Transaction not posted.
23307	Soft Error: Referenced Consumer ID for Contractor has been previously voided. Transaction not posted.
23313	Error: CID and Referenced CID are equal. Transaction not posted.

Status: Production	**Version:** 1.01	**ID:** 10003

Transaction: Case Manager

Effective Date: 1/1/2000

Definition:
This transaction allows the Regional Support Networks (RSN) to describe how an authorized person accessing the Case Manager Locator System (CMLS) can contact them by telephone when making an inquiry on a person who received a documented outpatient service within the most recent 12 months. The purpose is to provide a telephone number that is answered 24 hours a day, 7 days a week, by someone who can authenticate the caller and place them in contact with either a case manager or a clinician who has information about a specific consumer. The password is used by the RSN to authenticate the caller and is used by the RSN as a safeguard to prevent unauthorized release of information.
This information is used to support the Case Manager Locator System (CMLS). This transaction may be linked to any number of consumers identified by an RSN. *(See Consumer Case Manager Transaction for more details on how to link this transaction to a specific consumer.)*

Minimum Requirements: Each RSN will maintain one Case Manager transaction for each agency providing outpatient services within the most recent 12 months. Each RSN will also maintain a default Case Manager transaction to contact the RSN within any 24-hour day. The "Case Manager ID" for these default records will be "-AGENCY". The word agency must be in all upper case and be prefixed with a hyphen.

Transaction ID: Value "100.01"

Action Code: Value:
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Agency providing Case Management)*
Case Manager ID *(Unique ID assigned by the Agency or RSN - see minimum requirements above for default value.)*

Body: Case Manager Phone *(Primary - enter 10 digits including Area Code then extension or other)*
Case Manager Comment *(Primary)*
Case Manager Phone *(Secondary)*
Case Manager Comment *(Secondary)*

Case Manager Password

Notes: Two sets of telephone numbers and comments are allowed. When the telephone numbers and comments are displayed on the Case Manager Locator System screen, the primary telephone number is aligned with the primary comment; the secondary telephone number is aligned with the secondary comment. The telephone numbers should include the area code. If no area code is given, then someone using the Case Manager Locator System may not be able to contact the RSN if they trying to call from outside the RSN's area code.

Edits:

Message Number	Message
23100	Soft Error: No Case Manager row found for RUID %s and CaseManagerID%s. Delete not posted.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23003	Error: Reporting Unit ID%s unknown. Transaction not posted.
23038	Error: Case Manager Primary Phone cannot be blank or null. Transaction not posted.
23039	Error: Case Manager Password cannot be blank or null. Transaction not posted.
30037	Warning: Invalid primary phone number - Need full 10 digits including Area Code.

Note % signs above replaced by actual ID values when message sent.

Status: Production	**Version:** 2	**ID:** 10007

Transaction: CDMHP Investigation

Effective Date: 1/1/2000

Definition:
A designated Community Mental Health Professional (CDMHP) is the only person who can perform an ITA investigation that results in a detention and revocation. A crisis worker who is not a CDMHP can initiate this investigation but in order for a detention to take place, it is mandated (RCW 71.05 for adults, RCW 71.34 for children 13 and over) that the CDMHP investigate and make a determination. Therefore, all investigations reported are derived from the investigation resulting from the findings of a CDMHP. Do not report investigative findings of the crisis worker unless the crisis worker is also a CDMHP.
The intent of this transaction is to record CDMHP investigations only. Activities performed by a CDMHP including crisis intervention, case management, or other activities, while important are not collected by this transaction. Each RSN determines which specific actions come under an investigation. The MHD recommended criteria for when a CDMHP activity becomes an 'investigation'

is when the decision to investigate has been made and the CDMHP reads the person his/her rights. The trigger is reading the person his/her rights.
This transaction identifies all investigations by the CDMHP, even if the CDMHP is also classified as a crisis worker. An investigation can result in: a detention, which is 72 hours; a return to inpatient facility with a revocation of a court ordered less restrictive alternative (LRA) petition filed; a filing of a petition recommending an LRA extension; a referral for voluntary in-patient or outpatient mental health services, a referral to other community resources; or no action based on mental health needs. When Code 5 is used for Investigation Outcome, the Legal Reasons for Detention/Commitment should be codes A-D and not Z.

Transaction ID: Value "160.02"

Action Code: Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Investigation Date
Investigation Start Time

Body: Investigation County
Investigation Outcome
Reporting Unit ID *(State Hospital, Community Hospital or Freestanding Evaluation and Treatment Center where consumer was placed for inpatient services. Leave blank or null if not placed for inpatient services.)*
Legal Reason for Detention/Commitment
Return to Inpatient/Revocation Authority

Note: This transaction is not used to report "crisis services". These services are reported by using the "HIPAA 837P Outpatient Service" transaction.
If the Legal Reasons for Detention/Commitment contain contradictory code values (e.g. AZ) the "Z" will be discarded and a warning will be produced in the exception report.

Edits:

Message Number	Message
23098	Soft Error: Record does not exist. Delete rejected.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
22172	Warning: Time is invalid. Time should be HHMM and between 0000 and 2399.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID.

	Transaction not posted.
30001	Error: Investigation Outcome required. Transaction not processed.
23154	Error: RUID not valid for Inpatient facility. Transaction not posted.
23155	Error: Invalid Return to Inpatient/RevocationAuthority Code.
30038	Error: Invalid Investigation County Code. Transaction not processed.
30039	Error: Invalid Legal Reason for Detention/Commitment. Transaction not posted.

Status: Production	**Version:** 1	**ID:** 200137

Transaction: Clear Month of Service

Effective Date: 1/1/2002

Definition:
This transaction is used to remove all outpatient/inpatient service transactions for a given RSN and month of service. Use this transaction when you intend to resubmit all inpatient or outpatient services for a given month. Please consult with MHD IS staff before submitting this transaction. Special processing will be required to deal with data from HIPAA transactions, which can be reset to initial values but not deleted.

Transaction ID: Value: "077.02"

Primary Key: Reporting Unit ID *(for the RSN)*
Month of Service *(CCYYMM)*

Body: Type of Service Transaction
"O" = All OP Service including 837P HIPAA Transactions
"ET" = All E&T Service including 837I Transactions
"CHA" = All Community Hospital Authorizations: For removing old transactions with Month of Service dates prior to HIPAA implementation
"CHB" = All Community Hospital Payment Summary For removing old transactions with Month of Service dates prior to HIPAA implementation)

Edits:

Message Number	Message
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
30015	Error: Month of Service is invalid date format. Transaction not processed.

Status: Phased Out	Version: 2	ID: 200136

Transaction: Community Hospital Authorization (076.01)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See Previous Data Dictionary for data and format requirements.

Status: Phased Out	Version: 2	ID: 200106

Transaction: Community Hospital Payment Summary (075.01)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See Previous Data Dictionary for data and format requirements.

Status: Production	Version: 1.03	ID: 10006

Transaction: Consumer Demographics

Effective Date: 1/1/2002

Definition:
The information contained in this record is used to identify a person. Most information stored in the MHD-CIS is aggregated by identifying unique person records. This transaction allows for establishing in the MHD-CIS a unique identifier, the "Consumer ID", for a person by the Regional Support Network and to provide limited information that describes the person - such as name, birth date, SSN, etc. This transaction must be successfully processed before any other transaction referencing the "Consumer ID" will be accepted.

Transaction ID: Value: "020.05"

Action Code: Value:
"A" Add
"C" Change

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID

Body: Surname
Given Names
Gender
Date of Birth
Race
Ethnicity
Hispanic Origin
Preferred Language
Social Security Number
Sexual Orientation

Edits:

Message Number	Message
23096	Soft Error: Consumer ID for RSN ID has been voided. Add/Change not posted.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23024	Error: Surname is blank or null. Transaction not posted.
23023	Error: Given Name is blank or null. Transaction not posted.
22121	Warning: Date of Birth is blank or null.
22120	Warning: Date of Birth is not valid, should be 8 digits in format CCYYMMDD.
30040	Error: Date of Birth can not be beyond current date. Transaction not posted.
22130	Warning: Gender is invalid, set to 3 - Unknown.
22131	Warning: Gender is blank or null, set to 3 - Unknown.
23026	Error: Ethnicity Code is null or blank. Transaction not posted.
23025	Error: Ethnicity Code is not valid. Transaction not posted.
24725	Warning: Ethnicity Code submitted is no longer in use. Please correct and submit again.
23028	Error: Hispanic Origin code is null or blank. Transaction not posted.
23027	Error: Hispanic Origin code is not valid. Transaction not posted.
23032	Error: Language code is null or blank. Transaction not posted.
23029	Error: Language code is not valid. Transaction not posted.
22000	Warning: Social Security Number is blank.

22001	Warning: Social Security Number is not valid. Set to blank.
23036	Error: Sexual Orientation Code is blank. Transaction not posted.
23035	Error: Sexual Orientation Code is invalid. Transaction not posted.

Status: Production	**Version:** 1.02	**ID:** 10012

Transaction: Consumer Periodics

Effective Date: 1/1/2002

Definition:
Consumer Periodics are collected at intake, and reported at least every 3 months, or on change. Please note that a warning message will be posted for outpatient service transactions where there does not exist a Consumer Periodics within the last 3 months of service.

Transaction ID: Value "035.06"

Action Code:

Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Month of Periodic *(CCYYMM) (Please note that the day is not included)*

Body: Employment Status
Education
Grade Level
Living Situation

County of Residence
Priority Code
Diagnosis - OPTIONAL Four occurrences - use ICD9 format
This is the predominant mental health diagnosis within the period. It may be different than a specific medical encounter diagnosis as reported using a HIPAA 837 transaction.
Use Primary Diagnosis as first entry if provided.
Use Secondary Diagnosis as next entry if provided.
Use Third and Fourth diagnosis as appropriate.
Use tabs to skip optional entry.
Impairment Kind
Annual Gross Income
Number of Dependents
GAF - *(Global Assessment of Functioning)*
CGAS - *(Children Global Assessment Scale)*
DC03 - *(Assessment for Children 5 years of age or younger)*

Edits:

Message Number	Message
23092	Error: Contractor ID provided not valid. Transaction not posted
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
30031	Error: CID has been merged or deleted. Transaction not posted.
30014	Error: GAF, CGAS and/or DC03 contain invalid values. Transaction not posted.
30018	Error: Non Numeric Gross Income. (Money field and Nulls are allowed) Transaction not posted.
30019	Error: Non Numeric Number of Dependents. Transaction not posted.
22192	Warning: Impairment Kind codes field is blank or null. Set to Z (None).
30020	Error: One or more Impairment Kind code is invalid. Transaction not posted.
30021	Warning: Priority Code is blank or null. Set to 'O'.
30022	Error: Invalid Priority Code. Transaction not posted.
30023	Warning: Living Situation blank or null. Set to '99' = Unknown.
30024	Error: Invalid Living Situation Code. Transaction not posted.
30025	Warning: Grade is blank or null. Set to '99' = Unknown.
30026	Error: Invalid Grade. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
30028	Error: Invalid Education code. Transaction not posted.
30029	Warning: Employment is blank or null. Set to '9' = Unknown.
30030	Error: Invalid Employment code. Transaction not posted.
30034	Warning: Should have at least one non-zero assessment: GAF, CGAS, or DC03.

Status: Production	**Version:** 1.01	**ID:** 10005

Transaction: Consumer's Case Manager

Effective Date: 1/1/2000

Definition:
Each consumer identified by a Regional Support Network (RSN) may be assigned to a "Case Manager" for use within the Case Manager Locator System (CMLS). This transaction associates the "Case Manager" with the "Consumer Demographic" transaction. Each consumer identified by a "Consumer Demographic" record may reference one and only one "Case Manager" record; however, each "Case Manager" record may be referenced by many "Consumer Demographic" records.

Note: If a consumer has on file, with MHD/CIS, any outpatient services within the past 12 months, then the demographic information will be made available through CMLS. If no Case Manager has been assigned to that consumer by this transaction, then CMLS will try to locate the default Case Manager for the agency that provided the most recent outpatient service. In the event there is no default Case Manager record documented for that agency, then CMLS will use the default Case Manager for the RSN.

Transaction ID: Value: "011.01"

Action Code: Value:
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor ID or RSN ID)*
Consumer ID

Body: Case Manager ID *(Unique ID assigned by the RSN or Agency - must first be recorded with Case Manager transaction)*
Reporting Unit ID *(Agency providing Case Management)*

Edits:

Message Number	Message
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23314	Error: Case Manager transaction not found for CaseMgrID and CaseMgrRUID. Transaction not posted.
23011	Error: No Consumer Case Manager data found for RUID %s, CID %s. Delete not posted.

23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.

Note % signs above replaced by actual ID values when message sent.

Status: Phased Out Replaced by HIPAA 837I	**Version:** 2	**ID:** 10009

Transaction: E&T Inpatient Service (070.04)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See Previous Data Dictionary for data and format requirements.

Status: Production	**Version:** 1.01	**ID:** 10001

Transaction: Header

Proposed Effective Date: 1/1/2000

Definition:
This transaction is an identifier and is the first record that goes in a batch file. The Header tells what number the batch is, the originator, and the date sent.

Transaction ID: Value: "000.01"

Body: Batch Date
Submitting Reporting Unit ID
Batch Number

Note: This transaction is required as the first record of each batch and all batches are processed in Batch Number order.

Edits:

Message Number	Message
23300	SAID %s is not a valid reporting unit ID.
23301	Batch number %s does not exist for SAID %s.

Note % signs above replaced by actual ID values when message sent.

Status: Production	**Version:** 1	**ID:** 10017

Transaction: ITA Hearing

Effective Date: 1/1/2000

Definition:
This transaction documents each hearing under the Involuntary Treatment Act filed in a specific county. This excludes filings at a State Hospital. If multiple hearings are held for the same person on the same day, record the decision of the court for the most recent hearing. If no decision is made at a hearing and the case is continued to another day, do not record the result of that hearing. Record only those hearings where a court makes a decision such as to detain, revoke, conditionally release, or dismiss.

Transaction ID: Value "162.02"

Action Code:

Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Hearing Date

Body: Hearing Outcome
Reporting Unit ID *(Community/State Hospital or Evaluation and Treatment Center number where the consumer was ordered to inpatient; otherwise leave blank or null)*
Hearing County

Edits:

Message Number	Message
23098	Soft Error: Record does not exist. Delete rejected.
30005	Error: Invalid RUID for Eval and Treatment Ctr or Hospital. Transaction not processed.

23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23003	Error: Reporting Unit ID %s unknown. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
30003	Error: Hearing Outcome Code is invalid. Transaction not processed.
30004	Error: Invalid Hearing County Code. Transaction not processed.

Note % signs above replaced by actual ID values when message sent.

References:

REVOCATION - ***Outpatient Treatment or Care - Conditional Release - Procedures for Revocation*** - As provided in RCW 71.05.340(3) - " If the hospital or facility designated to provide outpatient care, the designated county mental health professional or the secretary determines that a conditionally released person is failing to adhere to the terms and conditions of his or her release, or that substantial deterioration in the person's functioning has occurred, then, upon notification by the hospital or facility designated to provide outpatient care, or on his or her own motion, the designated county mental health professional or the secretary may order that the conditionally released person be apprehended and taken into custody and temporarily detained in an evaluation and treatment facility in or near the county in which he or she is receiving outpatient treatment until such time, not exceeding five days, as a hearing can be scheduled to determine whether or not the person should be returned to the hospital or facility from which he or she had been conditionally released. "

PETITION - ***Petition for Initial Detention*** - As provided in RCW 71.05.160 - " Any facility receiving a person pursuant to RCW 71.05.150 shall require a petition for initial detention stating the circumstances under which the person's condition was made known and stating that such officer or person has evidence, as a result of his personal observation or investigation, that the actions of the person for which application is made constitute a likelihood of serious harm to himself or others, or that he is gravely disabled, and stating the specific facts known to him as a result of his personal observation or investigation, upon which he bases the belief that such person should be detained for the purposes and under the authority of this chapter. "

Petition for Involuntary Treatment or Alternative Treatment - As provided in RCW 71.05.240 - " If a petition is filed for fourteen day involuntary treatment or ninety days of less restrictive alternative treatment, the court shall hold a probable cause hearing within seventy-two hours of the initial detention of such person as determined in RCW 71.05.180, as now or hereafter amended. "

Petition for Additional Confinement - As provided in RCW 71.05.290 - " At any time during a person's fourteen day intensive treatment period, the professional person in charge of a treatment facility or his professional designee or the designated county mental health professional may petition the superior court for an order requiring such person to undergo an additional period of treatment."

Petition for Release - As provided in RCW 71.05.480 - " Nothing contained in this chapter shall prohibit the patient from petitioning by writ of habeas corpus for release."

DETENTION - ***Detention of Mentally Disordered Persons for Evaluation and Treatment*** - As provided in RCW 71.05.150 - " When a mental health professional designated by the county receives information alleging that a person, as a result of a mental disorder, presents a likelihood of serious harm to others or himself, or is gravely disabled, such mental health professional, after investigation and evaluation of the specific facts alleged, and of the reliability and credibility of the person or persons, if any, providing information to initiate detention, may, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention. "

Detention Period for Evaluation and Treatment - As provided in RCW 71.05.180 - " If the evaluation and treatment facility admits the person, it may detain him for evaluation and treatment for a period not to exceed seventy-two hours from the time of acceptance as set forth in RCW 71.05.170. The computation of such seventy-two hour period shall exclude Saturday, Sundays, and holidays. "

COMMITMENT ORDER - ***Definitions*** - As provided in RCW 71.05.020(5) - " 'Judicial Commitment' means a commitment by a court pursuant to the provisions of this chapter. " (i.e., dangerous to self, others, or gravely disabled).

INVESTIGATION - (The only reference to " investigation" in RCW 71.05 is found in RCW71.05.150 - see ***Detention*** above).

Status: Phased Out Replaced by HIPAA 837P	**Version:** 2	**ID:** 10013

Transaction: Outpatient Service (120.03)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See Previous Data Dictionary for data and format requirements.

MHD CIS Data Definitions

Last update: DRAFT for 2003

Data Definitions are listed alphabetically below. Those that will be replaced or impacted by HIPAA have been annotated and their definition will not be reproduced here. For HIPAA specific data definitions, refer to the appropriate HIPAA Transaction Implementation Guides.

Sub Object	Status	Version	ID
Action Code	Production	1.01	101001
Admission Date Replaced by HIPAA	HIPAA Definition	1.02	101039
Amount Paid by Medicare	HIPAA Definition	1	200118
Annual Gross Income	Production	1	200123
Authorization Number	HIPAA Definition	1.02	101083
Batch Date	Production	1.01	101003
Batch Number	Production	1.01	101004
Case Manager Comment	Production	1.01	101005
Case Manager ID	Production	1.01	101006
Case Manager Password	Production	1.01	101007
Case Manager Phone	Production	1.01	101008
CGAS	Production	1	200145
Claim Submit Identifier Replaced by HIPAA	HIPAA Definition	1	200140
Consumer ID	Production	1.02	101010
County Code	Production	1.01	101011
County of Residence	Production	1.02	200130
CPT Code Replaced by HIPAA	HIPAA Definition	1	200142

Date of Birth	Production	1.01	101014
Date Paid	HIPAA Definition	1	200110
DC03	Production	1	200147
Diagnosis Replaced by HIPAA except for Consumer Periodics where diagnosis is now optional	Production and HIPAA Definition	1	200131
Discharge Date Replaced by HIPAA	HIPAA Definition	1.02	101050
Discharge Disposition	Phased Out	1	200148
DRG Code	Phased Out	1	200143
Education	Production	1.02	101051
Employment Status	Production	1.02	101053
EPSDT Indicator Replaced by HIPAA	HIPAA Definition	1	200146
Ethnicity	Production	1.02	101017
GAF Score	Production	1	200135
Gender	Production	1.01	101019
Given Names	Production	1.01	101020
Grade Level	Production	1	200128
Health Care Service Location Replaced by HIPAA	HIPAA Definition	1	200126
Hearing County	Production	1	101077
Hearing Date	Production	1	101076
Hearing Outcome	Production	1	101078
Hispanic Origin	Production	1.01	101021
Impairment Kind	Production	1.02	101022

Investigation County	Production	1.01	101058
Investigation Date	Production	1.01	101059
Investigation Outcome	Production	1.01	101060
Investigation Start Time	Production	1.01	101061
Legal Reasons for Detention/Commitment	Production	1	101088
Legal Status Replaced by HIPAA	HIPAA Definition	1.02	101062
Living Situation	Production	1	200129
Minutes of Service Replaced by HIPAA	HIPAA Definition	1.01	101063
Month of Periodic	Production	1	200141
Month of Service	Production	1	200138
Number of Dependents	Production	1	200124
Person Identifier Code Replaced by HIPAA	HIPAA Definition	1.01	101018
Preferred Language	Production	1.02	101024
Priority Code	Production	1.02	101026
Provider Number	HIPAA Definition	1	200109
Race	Production	1	200144
Reimbursement Amount	HIPAA Definition	1	200116
Reporting Unit ID	Production	1.02	101027
Return to Inpatient/Revocation Authority	Production	1	101087
RSN at Discharge	Phased Out	1.01	200149
Service Date Replaced by HIPAA	HIPAA Definition	1.01	101067

Sexual Orientation	Production	1.01	101068
Social Security Number	Production	1.01	101033
Surname	Production	1.01	101071
Total Claim Charge	HIPAA Definition	1	200113
Total Recipient Payment	HIPAA Definition	1	200115
Total Third Party Payment Amount	HIPAA Definition	1	200114
Transaction ID	Production	1.02	101073
Type of Service Transaction	Production	1	200139

Status: Production	Version: 1.01	ID: 101001

DD: Action Code

Effective Date: 1/1/2000

Definition:
Most batch transactions sent to the Mental Health Division/Consumer Information System contain a code, which indicates that a given action takes place. Actions allowed on a given transaction are defined below.

Note: The Action Code is used in most transactions. The exceptions are listed below. These exceptions should not have a "Tab" inserted in the transaction to delineate the location of an Action Code.

1. Cascade Merge
2. Cascade Delete (Full/Partial)
3. Header

Maximum character length: 1

Code	Definition
A	Add a Record. If the record already exists as defined by the transaction's primary key, then replace the existing information with the new information contained in the body.
C	Change a Record. If the record does not already exist based on the transaction's primary key, then add a new record to the file.
D	Delete. If the record as identified by the transaction's primary key does not exists, then inform the Contractor that the MHD-CIS has no record to delete.

Status: Production	Version: 1	ID: 200123

DD: Annual Gross Income

Effective Date: 1/1/2002

Definition:

Average annual family income. Family defined as members who normally share living environment who share income. Does not include income of group home members, other shelter members or inpatient roommates. Use the information available or best estimation in determining this element. If the person is on SSI, or is eligible for Washington State medical assistance, assume that the person is below the Federal Poverty level. For inpatients this represents the income of family of residence. For foster children report the child's annual income (benefit). This is to be reported annually or if changed. Change represents an amount that would change the designated poverty level of the consumer or change to the sliding fee scales used by RSNs.

Format: This is a money field allowing $, commas and a period. Null values allowed if amount not reported.

Where used: Consumer Periodics

Status: Production	**Version:** 1.01	**ID:** 101003

DD: Batch Date

Effective Date: 1/1/1998

Definition:
Date a batch file of transactions was created by a submitting agency.

Maximum character length: 8

Format: CCYYMMDD

Where used: Header

Status: Production	**Version:** 1.01	**ID:** 101004

DD: Batch Number

Effective Date: 1/1/1998

Definition:
A sequential number assigned to the batch file by the submitting agency. When the batch number exceeds 99999 the submitting agency will reset the batch number to 00001.

Maximum character length: 5 (Fill with leading zeros).

Where used: Header

Status: Production	Version: 1.01	ID: 101005

DD: Case Manager Comment

Effective Date: 1/1/2000

Definition:
Free-form field for commenting on the phone numbers (e.g. daytime, nighttime, beeper, etc.) or for entering other case manager information.

This information is stored at the State for the purpose of supporting the Case Manager Locator System.

Maximum character length: 255 Variable Length

Note: Problems have been detected with posting long comments. At this time, please keep comments short while this problem is being resolved.

Where used: Case Manager

Status: Production	**Version:** 1.01	**ID:** 101006

DD: Case Manager ID

Effective Date: 1/1/1998

Definition:
A code established by a Contractor to uniquely identify the case manager or case management team for a given consumer. A case management team may consist of one or more case management staff who shares responsibility for the care of a consumer. Case Manager ID can be established only by the Contractor through the RSN/PHP.

Maximum character length: 10 Variable Length

Where used: Case Manager

Status: Production	**Version:** 1.01	**ID:** 101007

DD: Case Manager Password

Effective Date: 1/1/1998

Definition:
A keyword that identifies that the requester has authority to inquire about a consumer. The password is updated in accordance with the RSN's Policy on Security of Consumer Information. This password is used in the Case Manager Locator System (CMLS) on the MHD-CIS Intranet.

Maximum character length: 30 Variable Length

Where used: Case Manager

Status: Production	**Version:** 1.01	**ID:** 101008

DD: Case Manager Phone

Effective Date: 1/1/1998

Definition:
The phone number where the appointed case manager can be reached. It is important that the area code be included so that someone calling from outside a given RSN's area can reach the appropriate contact point. The recommended format is the full ten (10) digit phone number including the area code then any extension if known. This telephone number will be displayed in the Case Management Locator System exactly as entered.

Maximum character length: Minimum 10 - 20 Variable Length

Where used: Case Manager

Status: Production	**Version:** 1	**ID:** 200145

DD: CGAS

Effective Date: 1/1/2002

Definition:
Global Assessment Scale for Children 6 to 17 Years of Age. Specified Time Period: 1 month
Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g. 35, 58, 62). Rate actual functioning regardless of treatment or prognosis. Use code 000 for inadequate information

Maximum character length: 3 - (left zero fill)

The examples of behavior provided are only illustrative and are not required for a particular rating.

Code	**Definition**
91-100	Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc): likeable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms.
81-90	Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally 'blowups" with siblings parents, or peers).
71-80	No more than slight impairment in functioning at home, at school; or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know

	them.
61-70	Some difficulty in a single area, but generally functioning pretty well (e.g. sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
51-60	Variable functioning with sporadic difficulties or symptoms in several but not all-social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
41-50	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
31-40	Major impairment in functioning in several areas and unable to function in one of these areas, e.g. disturbed at home, at school, with peers or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent: such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
21-20	Unable to function in almost all areas, e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
11-20	Needs considerable supervision to prevent hurting others or self (e.g. frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestured communication, marked social aloofness, stupor, etc.
01-10	Needs Constant supervision (24-hr care) due to severely aggressive or destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

Where used: Consumer Periodics

Status: Production	Version: 1.02	ID: 101010

DD: Consumer ID

Effective Date: 1/1/2002

Definition:
The identifier established by a Contractor, which uniquely identifies a consumer. Once a Consumer ID has been submitted to the MHD-CIS, it is never deleted. Use this ID on all transactions that require the identification of a consumer.

Maximum character length: 20 Variable Length

Note: A Consumer ID is established in the MHD-CIS by submitting a Consumer Demographic transaction.

Where used: Consumer Demographics
Cascade Delete (Full/Partial)
Cascade Merge
CDMHP Investigation
Consumer Periodics
Consumer's Case Manager
ITA Hearing

Status: Production	Version: 1.01	ID: 101011

DD: County Code

Effective Date: 1/1/1998

Definition:
A code ranging from '01' through '40'. Codes '01' through '39' identify the 39 counties in alphabetical order. Code '40' represents an unknown county.

Maximum character length: 2 (left zero fill).

Code	Definition	Code	Definition
01	Adams	21	Lewis
02	Asotin	22	Lincoln
03	Benton	23	Mason
04	Chelan	24	Okanogan
05	Clallam	25	Pacific
06	Clark	26	Pend Oreille
07	Columbia	27	Pierce
08	Cowlitz	28	San Juan
09	Douglas	29	Skagit
10	Ferry	30	Skamania
11	Franklin	31	Snohomish
12	Garfield	32	Spokane
13	Grant	33	Stevens
14	Grays Harbor	34	Thurston
15	Island	35	Wahkiakum
16	Jefferson	36	Walla Walla
17	King	37	Whatcom
18	Kitsap	38	Whitman
19	Kittitas	39	Yakima
20	Klickitat	40	Unknown or out of state

Where used: Consumer Periodics (County of Residence)
CDMHP Investigations (Investigation County)
ITA Hearing (Hearing County)

Status: Production	Version: 1.02	ID: 200130

DD: County of Residence

Effective Date: 1/1/2002

Definition:
A code indicating the county where a person lives (or unknown). Do not change if the consumer is placed in an institutional setting,

Maximum character length: 2 (left zero fill).

Note: See County Code for values.

Where used: Consumer Periodics

Status: Production	Version: 1.01	ID: 101014

DD: Date of Birth

Effective Date: 1/1/1998

Definition:
The date a person was reported born.

Submit the date in the format CCYYMMDD. November 26, 1933 would be submitted on the batch transaction as 19331126.

Maximum character length: 8

Format: CCYYMMDD

Note: When a birth date is post (or greater than) a service date or the date is invalid, then all statistics related to these types of birth dates are usually attributed to the adult population.

Where used: Consumer Demographics

Status: Production	Version: 1	ID: 200147

DD: DC03

Effective Date: 1/1/2002

Definition:
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) is a product of eight years of work by ZERO TO THREE'S multidisciplinary Diagnostic Classification Task Force. The task was to develop the first comprehensive guide to assessment, diagnosis and treatment planning for mental health problems in children, from infants to toddlers. (See http://www.zerotothree.org)
Zero to 100 scale describes the child's level of functioning. Complements DSM-IV. Original Source: Zero to Three/ National Center for Clinical Infant Programs, 1994 Current Codes available from the Washington Institute for Mental Illness Research & Training (WIMIRT). Use code 000 for inadequate information.

Note: MHD will also use the DC03 for 4 and 5-year-old children. CGAS is used for 6-17 year olds

Maximum character length: 3 (left zero fill)

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200131

DD: Diagnosis

Effective Date: 1/1/2002

Definition:
The diagnosis, ICD-9CM format, for most recent or relevant treatment.

Maximum character length: 3 to 6 (Or tabbed over if not reported)

Note: ICD-9CM may be coded as three digits with no period.

Where used: Consumer Periodics

In the Consumer Periodics Transaction, Diagnosis is optional. Up to four diagnosis (ICD9 codes) may be entered. It represents the predominant mental health diagnosis for the period, which is a different business use than a specific encounter diagnosis as reported on a HIPAA 837 transaction.

Status: Production	**Version:** 1.02	**ID:** 101051

DD: Education

Effective Date: 1/1/2002

Definition:
Describes if a consumer is in a formal educational program. This includes home schooling.

Maximum character length: 1

Code	Definition
1	Full time education: (1-12 grade: 20+ hours a week; kindergarten and greater than 12th grade: 12+ hours a week)
2	Part time education: (1-12: less than 20 hours a week, K and greater than 12th grade: less than 12 hours a week)
8	Not in educational program.
9	Unknown.

Where used: Consumer Periodics

Status: Production	**Version:** 1.02	**ID:** 101053

DD: Employment Status

Effective Date: 1/1/2002

Definition:
Employment status of the consumer during the Consumer Periodic time frame.

Guidelines:

This field is required to be reported as part of Consumer Periodics. This status may be recorded as "Unknown/Missing" if the service rendered is one-time, classified as Emergency/Crisis, or an assessment of the employment could not be determined during the time period reported. MHD does not expect employment records for children under 16. However, if reported code 8 or code 9 could be used.

Maximum character length: 1

C	Definition
1	Employment Full-time: (35 hours or more paid employment per week).
3	Employment Part-time: (Less than 35 hours paid employment per week).
4	Supported Employment: (SE programs use a team approach for treatment, with employment specialists carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. Frequently coordinated with Vocational Rehabilitation benefits.
5	Employed sheltered workshops, onsite at SE or other treatment agency offices.
6	Volunteer work: (1 or more hours per week volunteer work).
7	Retired.
8	Not Employed.
9	Unknown/Missing.

Where used: Consumer Periodics

Status: Production	**Version:** 1.02	**ID:** 101017

DD: Ethnicity

Effective Date: 1/1/2002

Definition:
Taken from the Year 2000 census survey form as published by the Bureau of Census. Select one or more races to indicate what this person considers himself/herself to be.

If a person selects more than one code, enter each one in sequence. For example the selection of both White and Chinese would be coded as 010605. The first three digits (010) represents the first

ethnicity, the second three digits (605) are the next ethnicity and so on. If the information is not available or unknown, then code as 999. Do not use code '999' with any other code combinations.

For reporting purposes, multi ethnicity coding will be combined into a single category. This is to prevent counting the same client multiple times.

Maximum character length: Variable Length of 3 or multiple of 3 characters

Code	Definition
010	White
021	American Indian or Alaska Native
031	Asian Indian
032	Native Hawaiian
033	Other Pacific Islander
034	Other Asian
040	Black, African American, or Negro
050	Some other race
605	Chinese
608	Filipino
611	Japanese
612	Korean
619	Vietnamese
660	Guamanian or Chamorro
655	Samoan
999	Not reported/Unknown

Where used: Consumer Demographics

Status: Production	Version: 1	ID: 200135

DD: GAF Score

Effective Date: 1/1/2002

Definition:
Global Assessment of Functioning. Use code 000 for inadequate information.

Maximum character length: 3 - (left zero fill)

Use Axis V codes from DSM-IV.

Where used: Consumer Periodics

Status: Production	Version: 1.01	ID: 101019

DD: Gender

Effective Date: 7/1/1998

Definition:
A code indicating either Male or Female. Indicate the gender of male or female.

Maximum character length: 1

Code	Definition
1	Female
2	Male
3	Unknown

Note: The value "3" for "Unknown" should be avoided. In statistical reports that look at gender as "Male" and "Female" exclusively, the "Unknown" ***may be*** included with the "Male" population.

Where used: Consumer Demographics

Status: Production	**Version:** 1.01	**ID:** 101020

DD: Given Names

Effective Date: 1/1/1998

Definition:
The given/first/informal names of a consumer as provided by a Reporting Unit. (May include Title.)

In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name. Consistency is important here, because the last name and given names are both used as elements to uniquely identify the person across the system.

The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.

Maximum character length: 40 Variable Length

Where used: Consumer Demographics

Status: Production	**Version:** 1	**ID:** 200128

DD: Grade Level

Effective Date: 1/1/2002

Definition:

Identifies the highest-grade level completed by the consumer.

Maximum character length: 2 - (left zero fill)

Code	Definition
00	Preschool/kindergarten
01 - 12	List the specific grade completed, (Use 12 for GED)
13	Some College
14	2 year degree (AA, AS)
16	4 year degree (BA, BS)
18	Post-graduate education
99	Unknown, Never attended, or below pre-school

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 101077

DD: Hearing County

Effective Date: 1/1/2000

Definition:
The county where a court hearing was held.

Maximum character length: 2

See County Code for code values. County code "40" for "Unknown" will be rejected.

Where Used: ITA Hearing

Status: Production	Version: 1	ID: 101076

DD: Hearing Date

Effective Date: 1/1/2000

Definition:
The date of a court hearing.

Maximum character length: 8

Format: (CCYYMMDD)

Where used: ITA Hearing

Status: Production	Version: 1	ID: 101078

DD: Hearing Outcome

Effective Date: 1/1/2000

Definition:
Code representing the number of days committed as a result of a court order.

Note: No distinction is made between initial commitments/LRA and extensions. If the court orders another time period, round up to nearest time period.

Special Note for Codes 7 and 8: These are court-hearing outcomes based on petitions for revocation filed by the CDMHP. The CDMHP can return a person to inpatient status then file a petition for court determination. The court can revoke the LRA (Code 7) which substantiates the CDMHP's action and returns the person to inpatient for the remainder of their time. The court may also may return the person to the community on a less restricted alternative (Code 8) with the same or amended conditions.

Maximum character length: 1

Code	Definition
0	Dismissed
1	14 Day Commitment

2	90 Day Commitment or extension
3	180 Day Commitment or extension
4	90 Day LRA or LRA extension
5	180 Day LRA or LRA extension
6	Agreed to Voluntary Treatment
7	Revoke LRA
8	Reinstate LRA

Where used: ITA Hearing

Status: Production	**Version:** 1.01	**ID:** 101021

DD: Hispanic Origin

Effective Date: 1/1/1998

Definition:
A person of Mexican, Puerto Rican, Cuban, Central American or South American, or other Spanish origin or descent, regardless of race. The code is for primary self-reported Hispanic type. Roll-up code "000" may only be used with ITA and Crisis one-time services.

Use the code that describes the person's identification with Hispanic culture, origin or descent, in addition to the race/ethnicity recorded under Race/Ethnicity. If the RSN/PHP has conflicting views from their providers, the RSN/PHP will submit the most recent reported.

Every person should have an entry for both Ethnicity and Hispanic Origin codes.

Maximum character length: 3 - (left zero fill)

Code	Definition
000	General Hispanic
709	Cuban

722	Mexican/Mexican-American/Chicano
727	Puerto Rican
799	Other Spanish/Hispanic
998	Not Spanish/Hispanic
999	Unknown

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101022

DD: Impairment Kind

Effective Date: 1/1/2002

Definition:
The set of codes that identifies an individual's disability, in addition to the mental disorder for which they are being treated. The disability should have a major impact on the person and their ability to function. Multiple categories can be selected to describe the individual's impairment(s). Enter up to three applicable disability codes.

Maximum character length: 3 - Use up to 3 codes listed below (Variable Length).

THE DISABILITY SHOULD HAVE A MAJOR IMPACT ON THE PERSON AND THEIR ABILITY TO FUNCTION IN THE COMMUNITY AND TO PROCURE FOOD, CLOTHING, AND A SAFE PLACE TO LIVE.

Code	Definition
A	Development or intelligence; i.e., mental retardation or developmental disorder, organic brain syndrome.
C	Physical (unable to walk without assistance, unable to care for self, chronic illness).
D	Alcohol or drug dependence; i.e., dependence on alcohol or drugs which negatively affects the individual's ability to maintain a stable living arrangement, unable to

	remain in competitive employment, unable to provide adequate care for dependents, legal problems related to substance abuse.
E	Vision Impairments (does not include wearing glasses).
F	Hearing Impairments.
G	Other communication difficulties (speech and language, language comprehension. Does not include non-native speakers).
X	Other - Medical or physical disabilities not listed above.
Y	Unknown.
Z	None.

Where used: Consumer Periodics

Status: Production	**Version:** 1.01	**ID:** 101058

DD: Investigation County

Effective Date: 1/1/2000

Definition:
A code to indicate the county in which a person was investigated under the Involuntary Treatment Act.

Maximum character length: 2 (left zero fill).

See County Code for values

Where used: CDMHP Investigation

Status: Production	**Version:** 1.01	**ID:** 101059

DD: Investigation Date

Effective Date: 1/1/2000

Definition:

Date of an investigation under the Involuntary Treatment Act.

Maximum character length: 8

Format: CCYYMMDD

Where used: CDMHP Investigation

Status: Production	**Version:** 1.01	**ID:** 101060

DD: Investigation Outcome

Effective Date: 1/1/2000

Definition:
A code indicating the outcome to a person investigated.

Maximum character length: 1

C	**Definition**
1	Detention (72 hours as identified under the Involuntary Treatment Act, RCW 71.05).
2	Referred to voluntary Outpatient mental health services.
3	Referred to voluntary Inpatient mental health services.
4	Returned to Inpatient facility/filed revocation petition.
5	Filed petition-recommending LRA extension
6	Referred to non-mental health community resources.
9	Other.

Note: Code "1" if the person was informed of their rights and involuntarily detained. A person may have been informed of their rights and may have decided to be treated voluntarily. In this case, document this as code "2" or "3" for referral to a facility for either voluntary inpatient or outpatient mental health services.

Where used: CDMHP Investigation

Status: Production	Version: 1.01	ID: 101061

DD: Investigation Start Time

Effective Date: 1/1/2000

Definition:
Time of day an investigation was started.

Maximum character length: 4

Format: HHMM

Note: This field is used to separate multiple investigations for the same person on the same day. It may be left blank if there is only one investigation, or the Contractor may specify any value up to 4 characters in length to uniquely identify multiple investigations on the same day. It is recommended that a time value be submitted using a 24-hour clock. If multiple investigations are reported for the same person on the same day and no start time is stated, then the new investigation will overwrite any old investigation without a start time.

Where used: CDMHP Investigation

Status: Production	Version: 1	ID: 101088

DD: Legal Reasons for Detention/Commitment

Effective Date: 1/1/2000

Definition:
Identifies the basic reason for detaining a person for 72 hours or committing a person to inpatient treatment or a less restrictive alternative (LRA) under the Involuntary Treatment Act, RCW 71.05 for adults and RCW 71.34 for children 13 and over (Children under 13 may not be detained through the ITA process). If more than one reason applies, select all that apply.

Note: Up to 4 codes may be recorded if a detention took place.

Maximum character length: 4

C	Definition
A	Dangerous to self
B	Dangerous to others
C	Gravely disabled
D	Dangerous to property
Z	NA-person was not involuntarily detained under ITA

Where used: CDMHP Investigation

Status: Production	**Version:** 1	**ID:** 200129

DD: Living Situation

Effective Date: 1/1/2002

Definition:
Identifies the environment in which the client lives. Although reported on a 90-day cycle, the living situation for the last 30 days (where the consumer was the majority of the time) is the information to be reported.

Maximum character length: 2

Code	Definition
10	Private Residence without support: Individual lives in a house, apartment, trailer, boat, hotel, dorm, or barrack, Single Room Occupancy (SRO) and does not require routine or planned support to maintain his/her independence in the living situation. Includes children living with

	parents.
20	Private Residence receiving support: Individual lives in a house, apartment, trailer, boat, hotel, dorm, or barrack, Single Room Occupancy (SRO) and receives planned support to maintain independence in his/her private residence. This may include individualized services to promote recovery, manage crises, perform activities of daily living, and/or manage symptoms. Support services are delivered in the person's home environment. The person providing the support services may include a family member or a friend living with the client or a person/organization periodically visiting the home.
30	Foster Home: Individual resides in a Foster Home. A Foster Home is a home that is licensed by a County Department to provide foster care to children and adolescents. This includes Therapeutic Foster Care Facilities and adults in AFH.
40	24-Hour Residential Care: Individual resides in a residential care facility with care provided on a 24-hour, 7 day a week basis. Includes aggregate care and CCF facilities. This level of care may include a Group Home, Therapeutic Group Home, Board and Care, Crisis Residential, Residential Treatment, or Rehabilitation Center, or Residential Care/Treatment Facility and chemical dependency residential programs.
50	Institutional Setting: Individual resides in an institutional care facility with care provided on a 24-hour, 7 day a week basis. This level of care may include a Skilled Nursing/Intermediate Care Facility, Institute of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, DD Facility, or State Hospital.
60	Jail/Juvenile Correction Facility: Individual resides in a Jail and/or Correctional facility with care provided on a 24-hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.
70	Homeless/Shelter: A person has no permanent place of residence where a lease or mortgage agreement between the individual and the owner exists. A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is: A) a supervised publicly or privately operated shelter designed to provide

	temporary living accommodations, B) an institution that provides a temporary residence for individuals intended to be institutionalized, or C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).
80	Other.
99	Unknown: Information on an individual's residence is not available.

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200141

DD: Month of Periodic

Effective Date: 1/1/2002

Definition:
The year and month of the periodic information as reported by the clinician. Format: CCYYMM

Maximum character length: 6.

Where used: Consumer Periodics

Status: Production	Version: 1	ID: 200138

DD: Month of Service

Effective Date: 1/1/2002

Definition:
The year and month of service. Format: CCYYMM

Maximum character length: 6.

Where used: Clear Month of Service

Status: Production	Version: 1	ID: 200124

DD: Number of Dependents

Effective Date: 1/1/2002

Definition:
List number of individuals, in addition to the consumer, who rely on the annual family income. Family defined as members who normally share residence and who share income. Does not include group home members, other shelter members or inpatient roommates. For inpatients this represents the number of dependents in the family of residence. For foster children report dependent of 1.

Example: A family of father, mother, two natural children and one foster child. a) Foster Child is client; number of dependents is ‘1’. b) Mother is client, Number of Dependents is '4'; Self = 1, husband = 1, two natural children = 2 for a total of 4.

Maximum character length: 2

Where used: Consumer Periodics

Status: Production	Version: 1.02	ID: 101024

DD: Preferred Language

Effective Date: 1/1/2002

Definition:
This code identifies the language in which a person prefers to receive services.

Maximum character length: 2 (left zero fill).

Codes	Definition	Codes	Definition
00	Language Unknown	17	Hungarian
01	Japanese	18	Russian
02	Korean	19	Romanian
03	Spanish	20	Polish
04	Vietnamese	21	Greek
05	Laotian	22	Tigrigna
06	Cambodian	23	Amharic
07	Mandarin	24	Finnish
08	Hmong	25	Farsi
09	Samoan	26	Czech
10	Ilocano	27	Mien
11	Tagalog	28	Yakama
12	French	29	Salish
13	English	30	Puyallup
14	German	31	Thai
15	American Sign Language	99	Other Language
16	Cantonese		

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101026

DD: Priority Code

Effective Date: 1/1/2002

Definition:
Refer to RCW 71.24.025. An indicator of the relative seriousness duration and intensity of the presenting mental disorder of a particular person as well as distinguishing whether the consumer is a member of a targeted group as established by legislative mandate. Priority code is expected for crisis services. Providers may not have enough information about an individual to make a 'chronic' determination, but the provider should have enough information to make a seriously disturbed or seriously emotionally disturbed rating. However if a crisis worker can not determine a priority of chronic or serious, the priority code should be reported as acute. If a person is determined by the RSN at their sole discretion to be at risk, code them as 'A' acute, otherwise code 'O' for other. See WAC 388-0865-0150 for definitions of adult and child. Currently a child is one who has not reached his/her eighteenth birthday unless Medicaid eligible in which case a child is one who has not reached his/her twenty first birthday. Adults and Children conditional definitions are included below:

Maximum character length: 1

CODE	DEFINITION
A	Acutely Mentally Ill- a condition limited to a short-term severe crisis episode of mental disorder, grave disability, or presenting a likelihood of serious harm. Not to be coded if the individual meets criteria for "chronic", "serious", or "seriously emotionally disturbed".
C	Chronically Mentally Ill Adult- an adult who has a mental disorder and meets at least one of the following criteria: -2 or more inpatient hospitalizations with the last 2 years, -continuous psychiatric hospitalization or residential treatment longer for more than 6 months out the preceding year, -because of mental disorder for more than 1 year, unable to engage in gainful

	activity. Gainful activity is based on Public Law related to SSI and SSDI regulations for earned income. For WA State this translates to a monetary amount. Refer to SSA Publication No. 05-11015 February 2001
D	**Seriously Disturbed person- a person who has a mental disorder that causes major impairment in several areas of daily living. If the person is a child, this is a sufficient criterion. If they are an adult they must meet this or at least one of the following criteria :** -is gravely disabled or presents a likelihood of serious harm to themselves or others, or to property; -has been on conditional release, or under a less restrictive alternative order at some time during the preceding two years; -has continuing suicidal preoccupation or attempts.
E	**Severely emotionally disturbed child- is a child who has a mental disorder which is clearly interfering with their functioning in family, school or with peers, and meets one of the following criteria:** -has undergone involuntary treatment or out of home placement related to a mental disorder within the last two years; -is currently served by juvenile justice, child-protection/welfare, special education, or developmental disabilities; -is at risk of escalating maladjustment due to: -chronic family dysfunction involving a mentally ill or inadequate caretaker; -changes in custodial adult; -going to, residing in, or returning from out of home placement; -subject to repeated physical abuse or neglect; -drug or alcohol abuse; -homelessness.
O	Other- Does not meet the criteria for Acutely mentally ill, Chronically mentally ill, Seriously disturbed, or Severely Emotionally Disturbed.

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200144

DD: Race

Effective Date: 1/1/2002

Definition:
Code indicating the racial or ethnic background of a person as initially defined for reporting under HIPAA regulations on the HIPAA 834 Plan Enrollment form. Since the 834 Transaction is not currently used in the MHD/RSN transaction environment this data element is retained in the MHD Consumer Demographics transaction as a place holder for potential future use. If not entered on a Consumer Demographics Transaction (blank), the value will be calculated from the reported Ethnicity and Hispanic Origin

NOTE: The data elements Ethnicity and Hispanic Origin will continue being used to satisfy the other federal (reporting, funding and managed care) requirements until such time as there is a clarification from the competing federal authorities.

Maximum character length: 1 (leave blank if not reported)

Codes	Definition
7	Not Provided
A	Asian or Pacific Islander
B	Black
C	Caucasian
H	Hispanic
I	American Indian or Alaskan Native
N	Black (Non-Hispanic)
O	White (Non-Hispanic)

Where used: Consumer Demographics

Status: Production	Version: 1.02	ID: 101027

DD: Reporting Unit ID

Effective Date: 1/1/2002

Definition:
Unique identifier assigned to each unit reporting data on the MHD CIS System.

Maximum character length: 4 (left zero fill).

Note: This code is assigned by MHD to identify Reporting Unit. Since this list may change as Reporting Units are added or deleted over time, codes are kept on the MHD Intranet. For a complete list of centers or to establish a new ID, see instructions on the MHD Intranet.

Where used: Header
Clear Month of Service
Cascade Delete (Full/Partial)
Cascade Merge
Case Manager
CDMHP Investigation
Consumer Demographics
Consumer Periodics
Consumer's Case Manager
ITA Hearing

Status: Production	Version: 1	ID: 101087

DD: Return to Inpatient/Revocation Authority

Effective Date: 1/1/2000

Definition:
Identifies the basic reason for revoking a person. See RCW 71.05.340(3)(a) & (b).

Note: This element is specific to returning a consumer under LRA to inpatient treatment and the filing of a revocation petition. It distinguishes legal criteria used for person on LRA being returned to inpatient treatment. Use code "9" for all cases where the person is placed on LRA or not committed.

Maximum character length: 1

Codes	Definition
1	CDMHP determined detention during course of investigation per RCW 71.05.340(3)(a).
2	Outpatient provider requested revocation per RCW 71.05.340(3)(b) or RCW 71.34 for kids.
9	N/A.

Where used: CDMHP Investigation

Status: Production	**Version:** 1.01	**ID:** 101068

DD: Sexual Orientation

Effective Date: 1/1/1998

Definition:
A code that describes a person's voluntarily stated sexual orientation. This code should not be inferred by the clinician. The person should collect the information during assessment, on discharge or upon notification. Do not collect this information from individuals under 13 years of age.

Maximum character length: 1

Code	Definition
1	The person states they are heterosexual.
2	The person states they are gay, lesbian, or bisexual.
9	Unknown/Not voluntarily given by person.

Where used: Consumer Demographics

Status: Production	Version: 1.01	ID: 101033

DD: Social Security Number

Effective Date: 1/1/2000

Definition:
A number assigned by the Social Security Administration which uniquely identifies a person.

Maximum character length: 9

SSN Citing for Federal Regulations:
The collection of SSN is allowed under the following Federal regulations:

42CFR433.138

HCFA State Medical Manual (All Parts)(Pub. 45) SMM15 15802 - Use and Verification of Social Security Number (SSN)

The attempt should be made to collect the SSN whenever possible. The SSN however, may not always available for mental health consumers.

Where used: Consumer Demographics

Status: Production	Version: 1.01	ID: 101071

DD: Surname

Effective Date: 1/1/1998

Definition:
The surname/family/last name of a consumer as provided by an RSN/PHP. In general, follow the rules of the appropriate culture when determining which name is the surname. Consistency is important here because the last name will be used as one element to uniquely identify the person across our system.

Maximum character length: 30 Variable Length

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101073

DD: Transaction ID

Effective Date: 1/1/2002

Definition:
A code to indicate the type of transaction record to be processed in a batch file.

Maximum character length: 6

Transaction ID	Transaction Title
131.02	Cascade Delete (Full/Partial)
130.02	Cascade Merge
100.01	Case Manager
160.02	CDMHP Investigation
077.02	Clear Month of Service
076.01	Community Hospital Authorization - May be used until HIPAA transaction implementation. Once phased out of service this transaction would only be used for historical data updates.
075.01	Community Hospital Payment Summary - May be used until HIPAA transaction implementation. Once phased out of service this transaction would only be used for historical data updates.
020.04	Consumer Demographics
035.06	Consumer Periodics
011.01	Consumer's Case Manager
000.01	Header
070.04	ET Inpatient Service - Used until phased out and replaced by HIPAA transactions. Once phased out of service this transaction would only be used for pre-HIPAA historical data updates.

162.02	ITA Hearing
120.03	Outpatient Service - Used until phased out and replaced by HIPAA transaction. Once phased out of service this transaction would only be used for pre-HIPAA historical data updates.

Where used: Transactions identified in the previous table.

Status: Production	**Version:** 1	**ID:** 200139

DD: Type of Service Transaction

Effective Date: 1/1/2002

Definition:
Identifies the type of service transactions that are to be removed based on a given month and year.

Maximum character length: 3.

C	Description
O	All OP Services Transactions
ET	All E&T Services Transactions

Where used: Clear Month of Service

MHD-CIS HIPAA Transactions

Federal Standards – HIPAA Implementation Guides

The National Electronic Data Interchange (ANSI ASC X12N) Transaction Set Implementation Guides for HIPAA has complete specifications for the full HIPAA Transactions which are quite robust in content. The Transaction Guides and their Addendum are the official source for transaction specifications and data definitions. The CIS-MHD Data Dictionary will not attempt to duplicate the information in those guides, rather refer to appropriate sections by the page numbers.
These implementation guides provide standardized data requirements and content for all users of the HIPAA transactions. The purpose of the implementation guide is to expedite the goal of achieving a totally electronic data interchange health encounter/claims processing and payment environment. This implementation guides provides a definitive statement of what data translators must be able to handle. The implementation guides also specify limits and guidance to what a provider (submitter) can place in a transaction. The implementation guides are intended to be compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

Trading Partner Agreements

It is appropriate and prudent for data exchange partners to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.
First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.
Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system? Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.
It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values, which are not valid in this Implementation Guide
- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

Transaction Detail

Two standard MHD/CIS transactions are being replaced by HIPAA Transactions.

Sub Object	Status	Version	ID
HIPAA 837I replacing ET Inpatient Service	New	1	20001

HIPAA 837P replacing Outpatient Service	New	1	20002

Status: Production	**Version:** 1	**ID:** 20001

HIPAA Transaction: 837 Institutional (E&T)

Definition:
This transaction identifies a consumer's stay in an Evaluation and Treatment Facility

Effective Date: 10/17/2003

HIPAA FORMAT – See HIPAA Health Care Claim: Institutional 837 ASC X12N 837 (004010X096), its successors and subsequent HIPAA Transaction Guide Addenda.

- Interchange Control Header
- Functional Group Header
- Transaction Set Header
- Beginning of Hierarchical Transaction
- Transmission Type Identification
    - <1000A> Submitter Name
    - <1000A> Submitter EDI Contact Information
    - <1000B> Receiver Name
        - <2000A> Billing/Pay-To Provider Hierarchical Level
        - <2010AA> Billing Provider Name
        - <2010AA> Billing Provider Address
        - <2010AA> Billing Provider City/State/ZIP
        - <2010AA> Billing Provider Secondary Identification
        - <2010AA> Billing Provider Contact Information
            - <2000B> Subscriber Hierarchical Level
            - <2000B> Subscriber Information
            - <2010BA> Subscriber Name
            - <2010BA> Subscriber Address
            - <2010BA> Subscriber City/State/ZIP Code
            - <2010BA> Subscriber Demographic Information
            - <2010BC> Payer Name
                - <2300> Claim Level Information
                - <2300> Discharge Hour
                - <2300> Statement Dates
                - <2300> Admission Date/Hour
                - <2300> Institutional Claim Code
                - <2300> Principal, Admitting, E-Code, And Patient Reason For Visit Diagnosis Information
                - <2300> Other Diagnosis Information

        - <2310A> Attending Physician Name
        - <2400> Service Line
        - <2400> Institutional Service Line
- Transaction Set Trailer
- Functional Group Trailer
- Interchange Control Trailer

HIPAA TRANSACTION CONTENT – See HIPAA **Health** Care Claim: Institutional 837 ASC X12N 837 (004010X096) or its successor, 837 ADDENDA, and MHD/RSN Trading Partner Agreements.

Note: For the purposes of reporting E&T Inpatient Services not all portions of the HIPAA Transaction will be needed. MHD must be able to accept and process a full transaction however many "loops" (HIPAA term for or specific sets of data) will not be acted upon by MHD and therefore are not necessary to use.

See Appendix A: Trading Partner Agreements

Status: Production	**Version:** 1	**ID:** 20002

HIPAA Transaction: 837 Professional (Outpatient Services)

Definition:
This transaction documents outpatient services for a specific consumer.

Effective Date: 10/17/2003

HIPAA FORMAT – See HIPAA Health Care Claim: Professional 837 ASC X12N 837 (004010X098) its successors and subsequent HIPAA Transaction Guide Addenda.

- Interchange Control Header
- Functional Group Header
- Transaction Set Header
- Beginning of Hierarchical Transaction
- Transmission Type Identification
    - <1000A> Submitter Name
    - <1000A> Submitter EDI Contact Information
    - <1000B> Receiver Name
        - <2000A> Billing/Pay-To Provider Hierarchical Level
        - <2010AA> Billing Provider Name
        - <2010AA> Billing Provider Address
        - <2010AA> Billing Provider City/State/ZIP
        - <2010AA> Billing Provider Secondary Identification
        - <2010AA> Billing Provider Contact Information

        - <2000B> Subscriber Hierarchical Level
        - <2010BA> Subscriber Name
        - <2010BB> Payer Name
            - <2300> Claim Level Information
            - <2300> Prior Authorization or Referral Number
            - <2300> Medical Record Number
            - <2300> Health Diagnosis Code
            - <2400> Service Line
            - <2400> Professional Service
            - <2400> Date - Service Date
            - <2400> Line Item Control Number
- Transaction Set Trailer
- Functional Group Trailer
- Interchange Control Trailer

HIPAA TRANSACTION CONTENT – See HIPAA Health Care Claim: Professional 837 ASC X12N 837 (004010X098) or its successor, 837 ADDENDA, and MHD/RSN Trading Partner Agreements.

For the purposes of reporting Outpatient Services not all portions of the HIPAA Transaction will be needed. MHD must be able to accept and process a full transaction however many "loops" (HIPAA term for or specific sets of data) will not be acted upon by MHD and therefore are not necessary to use.

See Appendix A: Trading Partner Agreements

End of Attachment C.VI.b.

c. **_x_** Collect data on *mental health* services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply): Please see the attached Data dictionary.

1. **_x_** [Required] Recording sufficient patient data to identify the ~~provider~~ *CMHA* who delivered mental health services to Medicaid enrollees

2. **_x_** [Required]Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by ~~providers~~ *CMHA* and subcontractors as applicable to a mandatory enrollment, paid on a per member per month capitatied basis, for mental health services.

3. **_x_** [Required] Verifying the accuracy and timeliness of data

4. **_x_** [Required] Screening data for completeness, logic and consistency

5. **_x_** [Required] Collecting mental health service information in standardized formats to the extent

feasible and appropriate

6.___ Other (please describe):

d.___Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1.___ Health services (please specify frequency and provide a description of the data and/or content of the reports)

2.___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3.___ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4.___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e.___Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

f._**x**_Ensure that information and data received from ~~providers~~ *CMHA* are accurate, timely and complete.

g._**x**_Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

h.___Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.___ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.

j.___ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e. report cards). Please describe.

k.___The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PIHPs and/or providers). Please describe.

l.___ Other (please describe):

Section D. COST EFFECTIVENESS

Cost effectiveness has been proven in this waiver.

Section E. FRAUD AND ABUSE

States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. [Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)]

The State Auditor monitors and reports no findings of Fraud and Abuse. Staff from MHD and the RSNs attended training required by our contract. We found this training to be geared for fee-for-service and therefore, removed the requirement of attendance from our contractor.

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes.

I. State Mechanisms

a._x_ The State has systems to avoid duplicate payments (e.g., denial of claims for *mental health* services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

b.___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c._x_ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

The State auditor monitors for fraud and abuse. These reports have been submitted to CMS over the course of the waiver. There have been no findings.

d._x_ The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe.

The contract with the PIHP includes the marked terms from II. b. below.

e.___ Other (please describe):

II. MCO/PIHP/PAHP Fraud Provisions

a._x_ [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:

1.___ data is accurate, complete, and truthful based on best knowledge, information, and belief

2.___ certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO

3.___ certification is submitted concurrently with data

PIHPs are paid on a per member per month basis for all Medicaid enrollee. The RSN Administrator is required to provide daily written certification which attests, based on their best knowledge, information, and belief, the accuracy, completeness, and truthfulness of data submitted to the MHD.

b._x__[Required for MCO/PIHPs]The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:

1._x_ Written polices that articulate commitment to comply with all applicable Federal and State laws

2._x_ Designation of compliance officer and committee

3._x_ Effective training and education for compliance officer and plan employees.

The MHD, the RSNs, and the CMHA are requesting training of their staff by CMS on this issue to occur within the first six months of this waiver modification to create a joint understanding of exactly what is required by CMS of the MHD and of the PIHP. The internal plans and other requirements will be adjusted in a reasonable time after the training if necessary.

4._x_ Enforcement of standards through well-publicized disciplinary guidelines

5._x_ Provision for internal monitoring and auditing

6._x_ Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract

c. _x_ [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who is, or who is affiliated with, an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. _x_ The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. SPECIAL POPULATIONS

States may wish to refer to the October 1998 CMS document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a.__ [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint, item F.I. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

b.__ Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- Please check all items that apply to the State.

a._**x**_The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

This is a carved-out mental health program. The program is responsible for persons (with the exceptions of the excluded populations) of all ages who qualify for authorization to services through the access to care standards and meet the definition of medically necessary. The program does not discriminate based on physical disability.

b.___There are special populations included in this waiver program. Please list the populations.

c._**x**__The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies that serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

The PIHPs have over the course of this waiver period developed cross-system service protocols for children and older adults. These protocols were developed with their cross-system partners, consumers, family members, advocates and other interested parties. The implementation of these protocols will begin August 1, 2003.

d.___The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)

2.___ State/local funding sources

3.___ Other (please describe):

e.___The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.___ Access to services (please describe):

2.___ Quality of Care (please describe):

3.___ Coordination of care (please describe):

4.___ Enrollee satisfaction (please describe):

5.___ Other (please describe):

f._x_ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

Within DSHS, ADA compliance is monitored on a three-year cycle outside of the MHD. Within this current waiver modification cycle, the RSNs have not been monitored. Monitoring visits are being scheduled as this modification is being written.

MHD's QA & I team reviews new (provisional license) agencies for ADA compliance. They request the latest self-assessment for ADA compliance and look for any corrective actions. If they are county or RSN contractors QA &I ask to see their latest review activities on this issue. If the agency can't provide documentation of ADA evaluation then look about to see if there are any major access barriers (disabled parking, rails in bathrooms, wheel chair accessible, etc.). Often times, QA & I will request the completion the ADA form with a copy provided to MHD.

g.___The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

II. State Requirements for MCOs/PIHPs/PAHPs

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide results from all

monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint, item F.II. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

Upcoming Waiver Period Please check all the items that apply to the State or MCO/PIHP/PAHP.

a.___The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.

b.___As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO/PIHP/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.

c.___The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d.___The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If not checked, please explain by population.

e.___The State collects or requires MCOs/PIHPs/PAHPs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance?

g.___The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions

2.___ The identification of medical procedures to address and/or monitor the conditions.

3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.

4.___ Other (please describe):

h.___The State specifies requirements of the MCO/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

- other requirements for fair hearings found in 42 CFR 431 Subpart E.

I. Definitions (MCO/PIHP):

Upcoming Waiver Period --

a._**x**_[Required]The definition of action in the case of an MCO/PIHP means: Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a service;
- The failure to provide services in a timely manner
- The failure to act within timeframes required by 42 CFR 438.408(b); or
- For a resident of a rural area with only on MCO, the denial of the enrollee's request to exercise his or her right to obtain services outside the network.

b._**x**_ Appeal means a request for a review of an action.

c._**x**_ Grievance means an expression of dissatisfaction about any matter other than an action.

d.___ Please describe any special processes that the State has for persons with special needs.

II. Grievance Systems Requirements (MCO/PIHP):

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b

of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

The monitoring results of complaints, grievance and fair hearings were developed over the last two-waiver periods. The difficulty in identifying trends as the reporting across PIHPs was somewhat different from the beginning. That reporting difference was corrected, however, there is still not enough information to show trends and anomalies. The more clearly established sets of definitions of terms commonly used in reporting are providing much better information. Individual PIHPs are contacted and asked to understand and comment on anomalies reported, e.g. a significant increase or decrease in a particular reporting category from one time period to another. PIHPs have been asked to assist in the process of establishing a basis of comparison of performance across PIHPs and of establishing a method to incorporate the review of complaints, grievances and fair hearings into the local quality management process.

For the last reporting period, April through September 02, there were 21 grievances and 5 fair hearings filed.

The MHD was required to develop a plan under Condition #6 of the current waiver modification to develop and implement a process to assure procedures for written notice of denial of service, increase awareness of disenrollment, and access to grievance and fair hearing. That plan was submitted to CMS.

The PIHPs have gained a better understanding of their responsibility when a denial of service is initiated due to an enrolled consumer not meeting the definition of medical necessity for service.

The training for RSN and CMHA staff on fair hearing and grievance access will occur over the spring and summer of 2003, as described in our plan to meet the condition. QA & I will begin to track it's effectiveness in the fall. MHD will provide the updated reports in September 03 and December 04 per the requirements.

b. Please mark any of the following that apply:

1.___ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2._**x**_ Following this section is a list or chart of the number and types of ~~complaints (~~not in BBA) and/or grievances handled during the waiver period.

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Access	2	2		1
Dignity and Respect			3	
Quality/ Appropriateness	1		5	
Phone calls not returned				

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Service -- Intensity, Not Available, Coordination				
Consumer Rights	1			1
Physicians & Medications	2			1
Financial & Admin Svs				
Residential			4	
Housing				
Transportation				
Emergency Services				
Other				

3.___ There is consumer involvement in the grievance process. Please describe.

Upcoming Waiver Period -- Please check requirements in effect for MCO/PIHP grievance processes.

a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:

1._**x**_ MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

2._**x**_ An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits

(a)___ direct access without first exhausting the MCO/PIHP grievance process.

(b)_**x**_ exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed with regards to specific mental health grievance the state requires the consumer to exhaust grievances at the lowest level possible; first at the community mental health agency, then the PIHP, and then the Mental Health Division. The consumer may file a fair hearing with regards to mental health service only after they have exhausted their grievance rights.

Per DSHS rules a consumer may access fair hearing at any time for issues with regards to service and eligibility.

3._**x**_ Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

4.___ The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame.

5._**x**_ [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State for mental health the following consumer grievance process applies.

The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must comply with WAC 388-865-0255 or its successor.

6._**x**_ The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7._**x**_ The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PIHPs to acknowledge complaints and grievances, please specify:

8._**x**_ The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

9._**x**__ The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.

10._**x**_ The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

11.___ The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12._**x**_ Timeframes for resolution:

(a)_**x**_ Grievances are resolved within **_90_** days (may not exceed 90 days from date of receipt by MCO/PIHP)

(b)___ Standard appeals are resolved in ___ days (may not exceed 45 days from date of receipt by MCO/PIHP).

(c)___ Expedited appeals are resolved in __ days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

13._**x**_ Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).

14._**x**_ The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).

15._**x**_ The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).

16.___ The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.

17.___ The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).

18._**x**_MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

19.___The State reviews information on each MCO/PIHP's appeals as art of the State quality strategy.

20._**x**_The State and/or MCO/PIHP have ombuds programs to assist enrollees in the appeals, grievance, and fair hearing process.

21.___Other (please specify):

III. PAHP Requirements

1.___ [Optional] PAHPs have an internal grievance system. Please describe.

2.___ [Required] PAHP enrollees have access to the State fair hearing process.

Section H. ENROLLEE INFORMATION AND RIGHTS

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. Marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.IV.a).

I. Information – Understandable; Language; Format

Previous Waiver Period

a. [Required] Please provide copies of the brochure and informational materials for potential enrollees explaining the program and how to enroll.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. _x_ [Required] The State will ensure that materials provided to ~~potential enrollees and~~ enrollees by the State, ~~the enrollment broker,~~ and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

b. _x_ ~~Potential enrollee and~~ enrollee materials will be translated into the prevalent languages listed below (If the State does not require written materials be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1.___ Spoken by significant number of potential enrollees and enrollees .

2.___ The languages spoken by approximately ___ percent or more of the potential enrollee/enrollee population.

3._x_ Other (please explain):

The Department of Social and Health Services, the single state agency, identifies the following languages for translation.

Cambodian, Cantonese, Mandarin, Korean, Laotian, Russian, Spanish, Vietnamese

c. _x_ [Required] Oral translation services are available to all ~~potential enrollee~~s and enrollees, regardless of languages.

d. _x_ [Required] The State will have a mechanism in place to help enrollees and ~~potential enrollee~~s understand the managed care program. Please describe.

The state is producing the required informing materials for consumers.

e._x_[Required] Each MCO/PIHP will have a mechanism in place to help ~~potential enrollee~~s and enrollees understand the requirements and benefits of the plan. Please describe.

The state is producing the required informing materials for consumers.

f._x_ The State's and MCO/PIHP/PAHP information materials are available in alternative formats *when requested* that takes into consideration the special needs of those, for example, with visual impairments.

II. Potential Enrollee Information

Not applicable under this waiver all Medicaid eligible are enrolled.

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a.___[Required] Timing. The State or its contractor will provide the required information:

1. at the time the potential enrollee becomes eligible to enrollee in a voluntary program, or is first required to enrollee in a mandatory program.

2. Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

b. Content The State and/or its enrollment broker provides the following information to potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2.___ An initial notification letter

3.___ A form for enrollment in the waiver program and selection of a plan

4.___ Comparative information about plans

5.___ Information on how to obtain counseling on choice of MCOs/PIHPs

6.___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

7.___ A health risk assessment form to identify conditions requiring immediate attention.

8.___ [Required] General information about:

(a)___ Basic features of managed care;

(b)___ Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment

(c)___ MCO/PIHP/PAHP responsibilities for coordination of care

9.___ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):

(a)___Benefits covered

(b)___ Cost sharing (if any)

(c)___Service area

(d)___ Names, locations, telephone numbers of, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals)

(e)___Benefits available under state plan but not covered contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information.

10.__ Other items (please explain):

III. Enrollee Information

a. The State has designated the following as responsible for providing required information to enrollees: See wavier request above

1._**x**_ the State or its contractor

2.___ the MCO/PIHP/PAHP

b._x_[Required] Timing. The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as follows:

1._**x**__ For new enrollees, all required information within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment.

2.____ _ For existing enrollees:

(a)___ State must notify of disenrollment rights at least annually, and if there is a lock-in, by no less than 60 days before the start of each enrollment period.

This doesn't apply because WA state does not allow disenrollment

(b) x Notify all enrollees of right to request and obtain required information at least once a year.

(c) –x Provide written notice of any significant change in required information

(d) x MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

(c)_x_[Required] Content: The State, its contractor, or the MCO/PIHP/PAHP will provide the following information to all enrollees:

1._**x**_ Benefits covered

2._NA_Cost sharing

Not applicable and not allowed under this program for Medicaid clients.

3._**x**_ Individual ~~provider~~ *subcontracted community mental health agency* information -- name, location, telephone, non-English languages, ~~not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals)~~

4._**x**__ Benefits available under state plan but not covered under contract, including conscience clause

5._**x**_ Restrictions on freedom of choice within network

6._**x**_ Enrollee rights and protections

7._**x**_ Procedures for obtaining *mental health* benefits

8._**x**_ Extent to which *mental health* benefits may be obtained out of network ~~(including family planning)~~

9._**x**_ Which and how after hours and ~~emergency~~ *crisis* care *per this waiver* are provided including

- ~~Definition of emergency medical condition, emergency services, and post-stabilization services~~
- ~~No prior authorization for emergency services~~
- Procedure for obtaining ~~emergency~~ *crisis* services *including crisis numbers*
- ~~Location of emergency settings~~
- ~~Right to use any hospital for emergency care~~

10._NA_ Post-stabilization rules

Not applicable – emergency services are not covered under this waiver.

11._**x**_ Referral for specialty care

12.___ [Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe

to enrollees)

13._**x**_ State fair hearing rights
- Right to hearing
- Method for obtaining hearing
- Rules governing representation at hearing

14._**x**_ MCO/PIHP grievance, appeal, and fair hearing procedures and timeframes, including :
- Right to file grievances and appeals
- Requirements and timeframes for filing grievance or appeal
- Availability of assistance in filing process
- Toll-free number to file grievance or appeal by phone
- Continuation of benefits, including
  - Right to have benefit continued during appeal or fair hearing
  - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee
- Any appeal rights State makes available to provider

15._**x**_ Advance directives for psychiatric care per the waiver request.

16._**x**_ Physician incentive plan information upon request

17._**x**_ Information on structure/operation of plan, upon request

III. Enrollee Rights:

Upcoming Waiver Period -- Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights. The State requires:

a._**x**_[Required] MCOs/PIHPs to have written policies with respect to enrollee rights.

b._**x**_[Required] Ensures staff and affiliated ~~providers~~ *community mental health agencies and their staff* take those rights into account when furnishing *mental health* services to enrollees

c._**x**_[Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and Americans with Disabilities Act)

d._**x**_ [Required] The State will assure that each enrollee has the following rights:

1._**x**_ Receive information on their managed care plan

2._**x**_ Be treated with respect, consideration of dignity and privacy

3._**x**_ Receive information on mental health treatment options

4._x_ Participate in decisions regarding care, including right to refuse treatment

5._x_ Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation

6._x_ If privacy rules apply, request and receive copy of medical record and request amendments

7._x_ Be furnished mental health care services in accordance with access and quality standards.

e._x_[Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its ~~providers~~ *CMHAs* treat the enrollee.

f.___ Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint, item H.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

Enrollee rights in the public mental health system are found in many statutes and regulations, both state and federal. This has been identified as an issue by our QA & I team and has resulted in many corrective actions. However, due to the fact that these are hard to locate and at times even hard to understand there has been much discussion about what the MHD can do to make it easier for the CMHA and the consumers. There have been conversations with the Assistant Attorney General and the Office of General Council with regards to translating these rights into simple English and then translating them into the prevalent languages for use by the CMHA. MHD has reviewed advice to move with caution as this translation could result in misinformation. MHD will continue to work this issue however, in the mean time, it will still be required that CMHA and PIHPs make enrollees aware of their rights.

Upcoming Waiver Period -- Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a.___The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b.___The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.

c.___ The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):

d._**x**_The State will monitor the MCO/PIHP/PAHPs compliance with the enrollee rights provisions in the following manner (please describe):

The MHD will monitor using the mandatory EQR protocol.

Section I. RESOURCE GUIDE

Below are references that provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid inpatient health plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and

Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and

Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.